

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01062</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 2b Film G397 2/9/68 kk</div> <div>CERTIFICATE OF DEATH</div> <div>01060</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Edward Garrison Abel						Month Day Year January 27 1968			1:05 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		19 October 1908		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center			Farmer			Agriculture
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
West Virginia			Loudoun		Harpers Ferry			RFD 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Charles --- Abel			First Middle Last Jeanette --- Tribby						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			Not Available		The Medical Records Address The Clinical Center, Bethesda, Maryland 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> <u>1729</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1908</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>8 January 1968</u> , to <u>27 January 1968</u> , that (X) (we) last saw the deceased alive on <u>27 January 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph D. Croft, Jr.</u> MD DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>27 January 1968</u>	
22d. PHYSICIAN'S NAME (Type) Joseph D. Croft, Jr. MD					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		Jan. 30, 1968		Hillsboro Cemetery			Hillsboro Va.		
24. FUNERAL DIRECTOR Tyson Wheeler 1331 Rockville Pike Funeral Home Rockville, Maryland					25a. REC'D BY REGISTRAR DATE JAN 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

08010

30310



UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <i>Mae Ahearn</i>						2a. DATE OF DEATH Month Day Year <i>Jan 31 1968</i>			2b. HOUR MIN <i>1:35</i> M			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1/24/85</i>		6. AGE (In years lost birthday) <i>83</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTH PLACE (State or foreign country) <i>Chicag</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Office work U.S. Gov.</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Wash.</i>		13c. CITY OR TOWN <i>Wash.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>30 Ph Otisburg Ct. N.W.</i>				
14. FATHER'S NAME First Middle Last <i>John Ahearn</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Ellen Shanahan</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i>				16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mrs Harry Lum</i> Address <i>319 Connors Dr. Forest Hts. Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic C.V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (his hospital) attended the deceased from <i>1955</i> , 19 <i>---</i> , to <i>JAN 31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>JAN 31</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Delbert E. DeLawter MD</i>				22c. DATE SIGNED <i>1/31/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Delbert E. DeLawter MD</i>		22e. ADDRESS <i>3848 PARKER ST NW WASH DC</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>2-3-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Assumption Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Glenwood, Illinois</i>						
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>						25a. REC'D BY REGISTRAR <i>Wash. D.C.</i>		25b. REGISTRAR'S SIGNATURE <i>Frank Judge</i>		25c. DATE <i>FEB 5 1968</i>		

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01001

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01062	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>Anna Grace Alden</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <i>Jan 19</i> Year <i>1968</i>			2b. HOUR <i>6:05</i> AM					
3. SEX <i>Fe.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH <i>Sept. 25, 1982</i>	6. AGE (In years last birthday) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>		2c. DATE PRONOUNCED DEAD Month <i>Jan</i> Day <i>19</i> Year <i>1968</i>		2d. HOUR <i>6:05</i> AM	
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Kensington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Correll Hall Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Wash. D.C.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3840 Harrison St</i>		
14. FATHER'S NAME First <i>Lewis</i> Middle <i>D.</i> Last <i>Alden</i>			15. MOTHER'S MAIDEN NAME First <i>Levetta</i> Middle <i>S.</i> Last <i>Russell</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>579-60-0341</i>			17. INFORMANT <i>Belle L. Alden</i>			ADDRESS <i>see #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - Bronchial -</i>										<i>3 days</i>	
DUE TO, OR AS A CONSEQUENCE OF - (b) <i>Fracture Hip Left + Cerebral Thrombosis</i>										<i>5 Mo.</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis - Cardiovascular Disease</i>										<i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<i>9080</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>4:00 PM</i> <i>8/28 1967</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fall at Home Had stroke + Fract. of Hip</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>3840 Harrison St</i>		City or Town <i>Washington</i>		County <i>DC</i>		State <i>DC</i>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Jan 19, 1968</i>	
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>1/22/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>				23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>			
24. FUNERAL DIRECTOR <i>Jos. Gawler's Sons</i>						ADDRESS <i>5130 Wisconsin Av., Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>JAN 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>f Charles Judge</i>	

10010

10010

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

DATE: 10/10/68

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Denver Ray Alexander			2a. DATE OF DEATH Month Day Year January 21 1968			2b. HOUR AM 9:00 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9 February 1931		6. AGE (In years last birthday) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Needle Factory (Supv)		12b. KIND OF BUSINESS OR INDUSTRY Needle Factor			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE South Carolina		13b. COUNTY Salem		13c. CITY OR TOWN Salem		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #1	
14. FATHER'S NAME First Middle Last Fulton D. Alexander			15. MOTHER'S MAIDEN NAME First Middle Last Lucy Brooks						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 250-44-0854		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Type II, Hyperlipoproteinemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days 2 Years 36 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 2 January, 1968, to 21 January 1968, that (X) (we) last saw the deceased alive on 21 January 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence S. Cohen MD		22c. DATE SIGNED 1/21/68		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Alexander Cemetery		23d. LOCATION (City or Town) (County) (State) Little River, South Carolina			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR JAN 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

01010

01002

RECORDS OF DEATH



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "DEATH" and "RECORDS" are visible.]

2001 2 3 1002

1001

1002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01066												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												01067											
Item 6 Film G396 1/17/68 kk												CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
Russell						(None)						Allnutt						January 11 1968						11:45 AM											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.															
Male				White				8/13/1883				84 83 YRS.				MONTHS				DAYS															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
Maryland				USA								Montgomery Md.																							
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																	
Bethesda						Suburban						Retired Farmer						Farm																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER											
Maryland						Montgomery						Gaithersburg						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						403 E. Diamond Ave.											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						16b. SOCIAL SECURITY NO.						17. INFORMANT											
First Middle Last						First Middle Last						no						217-32-0190						Mr. David Allnutt Frederick, Md.											
Aden						J. Allnutt						Martha Virginia						Lucy						Patrick St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) 486x Uremia.																		4 Days																	
DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosis																		6 Days																	
DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral Pneumonia.																		14 Days																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
						HOUR A.M. Month Day Year																													
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION						City or Town County State																	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>												Street or R.F.D. No.																							
22a. I certify that (I) (this hospital) attended the deceased from 1/11, 1968, to 1/11, 1968, that (I) (we) last saw the deceased alive on 1/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE												DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED											
L. I. Lea																								1-11-68											
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
L. I. Lea												Gaithersburg, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)																	
Burial						1-14-68						Laytonsville,						Laytonsville Mont. Md.																	
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE																	
Francis H. Barber Laytonsville, Md.												DATE						JAN 15 1968						Charles Judge											

01688

0101

RECORD OF DEEDS

Marshall

Alfred

January 11 1958

1958

Male

White

6/16/1903

33 28

Marshall

USA

Marshall

Marshall

Marshall

Marshall

Marshall, Montgomery, California, 100 N. Grand Ave.

Marshall, Virginia, 7 N. Richmond

Marshall, Virginia, 7 N. Richmond, No. 21-72-0190

1-11-58

Marshall, No.

Marshall, No. 1-11-58

Marshall, No. 1-11-58

01067

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01065

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Bessie E. Ammiss					MAY 13 1968					4:40 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Fe.	W.	July 26, 1884		83 YRS.	MONTHS DAYS		HOURS MIN.		Jan. 13 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
VA.		U.S.A.		Montgomery - Md.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda.		4603 Maple Ave.				Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Montgomery		Bethesda.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4603 Maple Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
		Menefee								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
No				217-36-9647		Mrs. Bolitha Laws 4455 Lowell St, N.W. Washington, D. C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia - Smoke Inhalation.										5 min.
890X DUE TO, OR AS A CONSEQUENCE OF (b) House Fire.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
9160										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		4:20 P.M. Jan. 13 1968		House-caught on Fire.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
		Home		4603 Maple Ave. Bethesda Montgomery Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
		JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Jan 13, 1968		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
								Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		1-13-68		Ft. Lincoln Crematory, Prince George County, Md.						
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE JAN 19 1968		J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01068

01066

1. DECEASED-NAME (Type or print) Joseph First Middle Last			2a. DATE OF DEATH Month 1 Day 31 Year 68			2b. HOUR 10:30 P					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/3/98		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WATCHMAN		12b. KIND OF BUSINESS OR INDUSTRY D.C. Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., D.C.		13b. COUNTY D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6426 5th Street, N.W.					
14. FATHER'S NAME Hugo First Middle Last			15. MOTHER'S MAIDEN NAME Antoinette First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No			16b. SOCIAL SECURITY NO. 578-10-1381A			17. INFORMANT HUGO ARDIZZONE Address 800 KERWIN RD SILVER SPRING MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS 340X DUE TO, OR AS A CONSEQUENCE OF (b) INANITION DUE TO, OR AS A CONSEQUENCE OF (c) PROGRESSIVE NEUROLOGICAL DISORDER (MULTIPLE SCLEROSIS) 40 YEARS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 345X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 2 JAN, 1968 , to 31 JAN, 1968 , that (I) (we) last saw the deceased alive on 31 JAN 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Henry R. Wolfe, M.D.					DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/1/68		
22d. PHYSICIAN'S NAME (Type) HENRY R. WOLFE					22e. ADDRESS 1131 UNIV. BLVD. W., S.S. MD. 20902						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3 FEB 1968		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY			23d. LOCATION (City or Town) (County) (State) ROCKVILLE MD.				
24. FUNERAL DIRECTOR PINARDI FUNERAL HOME, INC. 1400 GEORGIA AVE. N.W. WASH., D.C. 20002					25a. REC'D BY REGISTRAR FEB 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]				

INTRODUCTION

01062

CERTIFICATE OF DEATH

01067

01069

1. DECEASED-NAME (Type or print) <i>Maggie</i>			2a. DATE OF DEATH Month <i>January</i> Day <i>3</i> Year <i>1968</i>			2b. HOUR <i>6:30</i> M		
3. SEX <i>Female</i>			5. DATE OF BIRTH <i>Feb. 23, 1869</i>			6. AGE (in years last birthday) <i>98</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>US</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH <i>Montgomery</i>			10. CITY OR TOWN OF DEATH <i>Fairland</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fairland Nursing Home</i>		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>			13a. STREET AND NUMBER <i>2101 Fairland Road,</i>		
13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Item # 10</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <i>Unknown</i>			15. MOTHER'S MAIDEN NAME <i>Unknown</i>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Montgomery Co. Welfare - Rockville, Md.</i>			17. ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Branchio Congestive heart failure</i> <i>485X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Branchio pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 days</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>441X generalized arteriosclerosis - old age</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		
21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from <i>5-3, 1962</i> , to <i>1-2, 1967</i> , that (I) (we) last saw the deceased alive on <i>1-2, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>John R. Spencer</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. DATE SIGNED <i>1-2-68</i>			22d. PHYSICIAN'S NAME (Type) <i>John R. Spencer</i>			22e. ADDRESS <i>BURTONSVILLE, MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>1/5/67</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Potomac Church Cem.</i>		
23d. LOCATION (City or Town) (County) (State) <i>Potomac, Maryland</i>			24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JAN 8 1968</i>		
25b. REGISTRAR'S SIGNATURE <i>John Charles Jones</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death.

01089

INSTITUTE OF DESIGN

01000

Project Group 2

Family Unit

COPIES

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01070		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01008	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) ARTHUR			First Middle Last BARR		2a. DATE OF DEATH Month 1 Day 18 Year 1968		2b. HOUR 12:30 AM
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH 7-31-1889		6. AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Hosp 4011 Randolph Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steno typist		12b. KIND OF BUSINESS OR INDUSTRY DAILY NEWS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 11 Hammond Road		14. FATHER'S NAME First Middle Last GEORGE BARR		15. MOTHER'S MAIDEN NAME First Middle Last Mary Spangler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 5780 99938A		17. INFORMANT MRS. Edith BARR		Address 11 Hammond Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) U Remia 403 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442 X (b) Renal ARTERIOsclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 month							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema Congestive Heart Failure							
19a. DATE OF OPERATION 1/18/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Emphysema		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/30, 1967 to 1/18, 1968 , that (I) (we) last saw the deceased alive on 1/18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE R.T. Benack MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED 1/18/68		22d. PHYSICIAN'S NAME (Type) R.T. Benack MD		22e. ADDRESS 4115 Colie Drive, Wheaton			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Port Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS 4434 Georgia Avenue		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE JAN 23 1968							

0100

STANDARD OF GRADE

07070



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
30M REV. 1/68

01071		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01069			
1. DECEASED-NAME (Type or print) <u>Clayton Eugene Baus</u>						20. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1968</u>		2b. HOUR <u>3:00</u> AM	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>August 20, 1893</u>		6. AGE (In years last birthday) <u>74</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>10009 Portland Road</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired Printer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>10009 Portland Road</u>	
14. FATHER'S NAME First <u>Albert</u> Middle <u>E.</u> Last <u>Baus</u>		15. MOTHER'S MAIDEN NAME First <u>Amanda</u> Middle <u>Rachina</u> Last <u>Dohner</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>578-09-8890</u>		17. INFORMANT <u>Mabel P. Baus</u> Address <u>10009 Portland Road Silver Spring, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>2001</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>2001</u> (b) <u>Lymphosarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Herpes Booster</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17-</u> , 19 <u>65</u> , to <u>1-18</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1-17</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22b. SIGNATURE <u>Russell B. Arnold M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 18, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>				22e. ADDRESS <u>1106 Spring Street, Silver Spring, Md., 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 20, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Adelphi Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> Address <u>8434 Georgia Ave. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

01071

01067

REPUBLIC OF CHINA

CHINESE GOVERNMENT

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01072

CERTIFICATE OF DEATH

01070

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5610 Southwick Street		d. STREET ADDRESS 5610 Southwick Street	
3. NAME OF DECEASED (Type or print) DOROTHY E. BASHWINER		4. DATE OF DEATH Month Jan. Day 14, Year 19 68	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1883
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Darwin C. Pavey		14. MOTHER'S MAIDEN NAME Mary E. Kellogg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-10-0610P	
17. INFORMANT Daughter Doris O. Haight		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 436.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331X (b) Advanced cerebral arteriosclerosis DUE TO (c) 204.9		INTERVAL BETWEEN ONSET AND DEATH 20 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compensated Heart Failure - compensated		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-1 , 19 62 , to 1/13 , 19 68 , that (I) (we) last saw the deceased alive on 1/13 19 68 , and that death occurred at 11:55 AM , from causes and on the date stated above.			
22a. SIGNATURE Ronald W. Barr		22b. DATE SIGNED 1/14/68	
22c. PHYSICIAN'S NAME (Type) Ronald W. Barr, MD		22d. ADDRESS 9613 Wadsworth Drive Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-68	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JAN 18 1968	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
25M 1/68

01073		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01071	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8611 Hartsdale Ave.			d. STREET ADDRESS 8611 Hartsdale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EDWARD GEORGE BATTY			4. DATE OF DEATH Month Jan. Day 2, Year 19 68		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1896		9. AGE (In years last birthday) yrs. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Ohio	
13. FATHER'S NAME Edwin G. Batty			14. MOTHER'S MAIDEN NAME Edith Holbrook		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW1		16. SOCIAL SECURITY NO.		17. INFORMANT wife Hazel F. Batty Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 412.9 IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease DUE TO (b) with sequelae of previous myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) (remote)					INTERVAL BETWEEN ONSET AND DEATH 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.01					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August, 1965 to January, 1968 , that (I) (we) last saw the deceased alive on Jan 1st, 1968 , and that death occurred at 5:20 A.M. , from causes and on the date stated above.					
22a. SIGNATURE Harold I. Passes		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/2/68.	
22c. PHYSICIAN'S NAME (Type) HAROLD I. PASSES MD		22d. ADDRESS 8612 HARTSDALE AVE Bethesda Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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01074

CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) Jeffrey William Beach			2a. DATE OF DEATH Month Day Year January 30, 1968			2b. HOUR P 7:18 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 24 June 1956		6. AGE (In years last birthday) 11 YRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. COUNTY ---		13c. CITY OR TOWN Landisville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 197 Cooper Avenue		14. FATHER'S NAME First Middle Last William H. Beach		15. MOTHER'S MAIDEN NAME First Middle Last Doris J. Mowery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia (Gram Negative)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Lymphocytic Leukemia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours 6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2043							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Dec. 30, 1967, to January 30, 1968, that (X) (we) lost saw the deceased alive on January 30, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE as found up MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 31 January 1968	
22d. PHYSICIAN'S NAME (Type) Arthur S. Levine, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-3-68		23c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery		23d. LOCATION (City or Town) (County) (State) Landisville, Penna.	
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE FEB 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01075

CERTIFICATE OF DEATH

01073

1. DECEASED-NAME (Type or print)			First HARRY	Middle LESLIE	Last BEALL	2a. DATE OF DEATH Month 1 Day 2 Year 68 1968			2b. HOUR 6:25AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-5-86		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED Male nurse			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DAMASCUS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER TOWN SPRING ROAD			
14. FATHER'S NAME First Middle Last WILLIAM - BEALL			15. MOTHER'S MAIDEN NAME First Middle Last VIRGINIA - WATKINS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-14-2872		17. INFORMANT Address MEDICAL RECORD DEPT. MONTGOMERY GENERAL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Arteriosclerosis Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>you</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia, L.H.L. Incarcerated Nerve, N. Angina</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <u>1118</u> <u>12</u> <u>18</u>						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>68</u> , to <u>1/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. H. Ligon</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/3/68</u>				
22d. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.					22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.			23d. LOCATION (City or Town) (County) (State) Browningsville, Md.				
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR DATE JAN 8 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>				

01073

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-51 (a)
30M REV. 7-78

01076		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01074	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Phoebe Alice Beall			2a. DATE OF DEATH Month Day Year Jan 1 1968			2b. HOUR 9A. M	
3. SEX Female		4. RACE C.		5. DATE OF BIRTH Nov. 19, 1891		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Chevy Chase, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda-Silver Spring, N.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York		13b. COUNTY Westlake		13c. STREET AND NUMBER 116 Westlake Road			
14. FATHER'S NAME First Middle Last William Esh			15. MOTHER'S MAIDEN NAME First Middle Last Mary Kelsey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na. (or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address John Beall (Son) 3685 Old Lee Highway Fairfax, Virginia 22030			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 15 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>31 Dec</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert Martyn MD				22c. DATE SIGNED 1 Jan 1968			
22d. PHYSICIAN'S NAME (Type) HERBERT MARTYN JR				22e. ADDRESS 4740 Chevy Chase Dr. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/4/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, P.G. Co., Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D.C.				25a. REC'D BY REGISTRAR DATE JAN 5 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (11)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First JOHN			Middle T.			Last BEAN			2a. DATE OF DEATH Month JAN. Day 2 Year 1968			2b. HOUR M	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH SEPT. 3, 1889			6. AGE (In years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS. HOURS 00 MIN. 00		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.							
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4710 IRIS STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED MINER			12b. KIND OF BUSINESS OR INDUSTRY COAL MINES							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN ECKHART			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
14. FATHER'S NAME First MARK Middle BEAN Last UNKNOWN			15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 214-01-6720A			17. INFORMANT 4710 IRIS ST., MRS. MARTHA JACKSON, ROCKVILLE, MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 428x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Myocarditis 3 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4222																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from Dec 7 , 19 67 , to Jan 2 , 19 68 , that (I) (we) last saw the deceased alive on Jan 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE A. W. Smith M.D.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type) A.W. SMITH			22e. ADDRESS 13018 GEORGIA AVE WHEATON, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 5, 1968			23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY			23d. LOCATION (City or Town) (County) (State) ECKHART, MD.							
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532			25a. REC'D BY REGISTRAR DATE JAN 9 1968			25b. REGISTRAR'S SIGNATURE Charles Judge										

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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Ralph			(None)	Bee	Month 1 Day 4 Year 68			M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		white		6-7-86		81 YRS.		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
West Virginia		U.S.A				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington San. + Hosp		Minerworker (Ret)		Same					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
West Virginia		Harrison Co.		Shinnston		YES <input type="checkbox"/> NO <input type="checkbox"/>		R # 2			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last		
Josiah			Bee	Jane Meredith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
						Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 DUE TO, OR AS A CONSEQUENCE OF (b) Lymphosarcoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs - 6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2001											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
Dec 15, 1967		Twice of Stomach			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec 3, 1967, to Jan 4, 1968, that (I) (we) last saw the deceased alive on Dec 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)							
Lyle H. Williams		Jan 4, 1968		Lyle H. Williams							
22e. ADDRESS		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan 7, 1968		Shinnston Masonic Cemetery		Shinnston W. Va.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR								25b. REGISTRAR'S SIGNATURE	
Walter Waters		JAN 9 1968								John Judge	

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UNITED STATES DEPARTMENT OF AGRICULTURE

STATIONER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. Page 1 of this certificate should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b OAKHAVEN NURSING HOME d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, SS. Md. d. STREET ADDRESS 614 GIST AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAE A. BELL		4. DATE OF DEATH 1 / 21 / 1968	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1885
9. AGE (In years last birthday) 82 yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Mins.
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pet. U.S. Gov.		12b. KIND OF BUSINESS OR INDUSTRY Bureau of Engr.	
13. FATHER'S NAME George F. BURROWS		14. MOTHER'S MAIDEN NAME ANNA TEACHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. George BURROWS	
17. INFORMANT George BURROWS		Address # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 174X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Pulmonary metastases (c) Breast Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 yr. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170X gen. arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/14/1968 to 1/21/1968 , that (I) (we) last saw the deceased alive on 1/20/1968 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones M.D.		22b. DATE SIGNED 1/22/68	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES, M.D., FACP.		22d. ADDRESS 30 PHYSICIAN MILL RD. ROCKVILLE, MD. 20851	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 24, 1968		23b. DATE THEREOF Jan 24, 1968	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City, town or county) (State) SUITLAND, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Walter		25. REC'D BY REGISTRAR JAN 23 1968	
25a. ADDRESS 3603 14th St NW		25b. REGISTRAR'S SIGNATURE Charles Judge	

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U.S. AIR FORCE
HONOLULU, HAWAII

JAN 2 1963

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Delia E Bennett</i>					2a. DATE OF DEATH Month <i>Jan</i> Day <i>8</i> Year <i>68</i>			2b. HOUR <i>1:10 P M</i>	
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>12/19/15</i>		6. AGE (In years last birthday) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>V.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont. Clarksburg</i>		13c. CITY OR TOWN <i>Clarksburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rt #1</i>	
14. FATHER'S NAME First <i>Casper</i> Middle <i>Joseph</i> Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i>Smith</i> Last <i>Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Hospital Records</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction - recent, remote</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerosis with occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 8, 1968</i> , to <i>Jan 8, 1968</i> , that (I) (we) lost the deceased on <i>Jan 8, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>DeWitt E. DeLawter</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Jan 8, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLawter</i>				22e. ADDRESS <i>Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Clarksburg</i>		23d. LOCATION (City or Town) (County) (State) <i>Clarksburg Mont Md.</i>			
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>				ADDRESS <i>Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR <i>JAN 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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RECEIVED OF DEATH

THE STATE OF NEW YORK
IN SENATE
January 11, 1908
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 11, 1907
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1908

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Francis H. ...
1-11-08
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Albany, N.Y.
J.B. Lippincott & Co. Printers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01081									
01079									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
NETAT			Marie BENNETT			Month Day Year January 27 68			9 ²⁰ A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		3-25-1886		81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Chevy Chase Nursing Center		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7709 Savannah Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			Address			
First Middle Last			First Middle Last						
Millard			Ticer			Johanna W. Kessler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			-			Kemper Sullivan-Son- Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>Several Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>Jan</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>16 Jan</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<u>John J. Damm</u>		<u>27 Jan 1968</u>		<u>JOHN J. DAMM</u>					
22e. ADDRESS		22f. ADDRESS							
		<u>4977 Bathing Lane Bethesda</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-31-1968		Glenwood Cemetery		Washington, D.C.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Lawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.				DATE FEB 5 1968		<u>Charles Judge</u>			

01001

01001

01001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01082					01080				
1. DECEASED-NAME (Type or print) Signe C. Benson					2a. DATE OF DEATH Jan 9 Day 9 Year 1968			2b. HOUR M	
3. SEX e		4. RACE White		5. DATE OF BIRTH Mar 27th 1878		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Sweden		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montg., Md.			
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Marylander Home of Rest		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 114 Elmore Ave		13b. COUNTY Englewood N.J.		13c. CITY OR TOWN Englewood N.J.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 114 Elmore Ave	
14. FATHER'S NAME First Unknown Middle --- Last ---			15. MOTHER'S MAIDEN NAME First Beda Middle Peterson Last ---						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Marie S. Collins Address 530 Whittier St. N.W. D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) --- DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 8/18 , 19 58 , to 1/9 , 19 68 , that (I) (we) saw the deceased alive on 1/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr M.D. DEGREE --- ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 1/10/68				
22d. PHYSICIAN'S NAME (Type) James P. Kerr, Md					22e. ADDRESS Damascus, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-13-68		23c. NAME OF CEMETERY OR CREMATORY FairView Mosallium		23d. LOCATION (City or Town) Fair View. (County) N. J. (State) ---			
24. FUNERAL DIRECTOR Ernest C. Gartner. Gaithersburg, Md.					25a. REC'D BY REGISTRAR JAN 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

01083

01081

1. DECEASED-NAME (Type or print) First: Brian Middle: - Last: Bielski			2a. DATE OF DEATH Month: January Day: 27 Year: 1968			2b. HOUR 6:05 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 26, 1968		6. AGE (in years last birthday) YRS. MONTHS DAYS 1 1	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12616 Milburn Lane		14. FATHER'S NAME First: Stanley Middle: Edward Last: Bielski		15. MOTHER'S MAIDEN NAME First: Joan Middle: Elizabeth Last: Tripp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Father as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776.2 Respiratory distress (syndrome) 4 45 PM DUE TO, OR AS A CONSEQUENCE OF (b) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) respiratory failure. 773.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Respiratory Distress Syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital), attended the deceased from 1/25, 1968, to 1/27, 1968, that (I) (we) last saw the deceased alive on 1/26/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Bogert M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/27/68	
22d. PHYSICIAN'S NAME (Type) C. BOGAERT				22e. ADDRESS 2817 - Stonybrook Dr. Bowie Md.			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 1/31/68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rock Pike		25a. REC'D BY REGISTRAR FEB 2 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]			

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01081

RECEIVED BY THE
DIVISION OF THE
GENERAL INVESTIGATIVE
DIVISION OF THE
DEPARTMENT OF JUSTICE

01081

Report of the
Investigation
into the
Activities of the
Communist Party
in the United States
and its
Branches

Volume 1
Part 1
Chapter 1
The Communist Party
in the United States
and its
Branches

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5100 Dorset Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle Riley Last BOGLE		4. DATE OF DEATH Month Jan. Day 23 Year 1968	
5. SEX Female	6. COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1888
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Don Railey		14. MOTHER'S MAIDEN NAME Zada Beardsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-60-3832	
17. INFORMANT Daughter		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 402X Congestive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2 , 19 68 , to 1/23 , 19 68 , that I last saw the deceased alive on 1/23 , 19 68 , and that death occurred at 10:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr Joseph Kenrick		ADDRESS (Street, city or town, state) 6450 Wisconsin Ave, Bethesda Md	
PHYSICIAN'S NAME (Type) DR JOSEPH KENRICK		DATE SIGNED 1/23/68	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-68	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Chicago, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 26 1968	
24b. REGISTRAR'S SIGNATURE Charles Judge			

01083

CERTIFICATE OF DEATH

01083

1. DECEASED-NAME (Type or print) BERLIN G. BRANN			2a. DATE OF DEATH Month January Day 20 Year 1968			2b. HOUR 6 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/6/1881		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland N.H. Fairland Rd. S.S.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrical Engineer		12b. KIND OF BUSINESS OR INDUSTRY BUR. OF NAVY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7904 Woodrow Place		14. FATHER'S NAME First Unknown Middle Unknown Last Unknown		15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO. 220-44-6250		17. INFORMANT Ralph F. Springmann		17a. ADDRESS 7902 Woodrow Place Cabin John, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500 (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4500 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Pulmonary Disease - old inactive TBC							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22c. DATE SIGNED 1/20/68	
22a. I certify that (I) (this hospital) attended the deceased from 1/20 , 19 68 , to 1/20 , 19 68 , that (I) (we) last saw the deceased alive on 1/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.T. Benack MD		22d. PHYSICIAN'S NAME (Type) R.T. BENACK MD		22e. ADDRESS 4115 Colie Drive, Wheaton, Md.		22c. DATE SIGNED 1/20/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Jan. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR Walter E. Carter		24a. ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR DATE Jan 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	
24b. ADDRESS Varner E. Pumphrey, Inc. Silver Spring, Md.		24c. ADDRESS 8434 Georgia Avenue		24d. ADDRESS 8434 Georgia Avenue		24e. ADDRESS 8434 Georgia Avenue	

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DP - Cleared With Medical Examiner - Dr. Reap

01023

OFFICE OF CHIEF

01023

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01086		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01084	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month 9 Day 1968 Year 1968	
GEORGE			WILLIAM	BREW, SR.			
3. SEX male		4. RACE white		5. DATE OF BIRTH Aug. 14, 1874		6. AGE (In years last birthday) 93 YRS.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Masonry Contractor		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4407 - Franklin St.		14. FATHER'S NAME First Middle Last Michael Brew		15. MOTHER'S MAIDEN NAME First Middle Last Catherine Brew			
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 578-03-6016		17. INFORMANT Mrs. Catherine Buckley, Daughter, Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.9 Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 5 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-14-66 to 1-9-68, that (I) (we) last saw the deceased alive on 1-9-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. P. Brland		DEGREE C. P. Brland		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-9-68	
22d. PHYSICIAN'S NAME (Type) C. P. Brland		22e. ADDRESS Washington DC 20016					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/12/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, P.G., Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D. C.				25a. REC'D BY REGISTRAR JAN 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

X

01087

CERTIFICATE OF DEATH

01085

1. DECEASED-NAME (Type or print) <i>Lord</i>		First		Middle		Last		2a. DATE OF DEATH Month <i>January</i> Day <i>6</i> Year <i>1968</i>				2b. HOUR <i>9:15 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov 30, 1882</i>				6. AGE (if years last birthday) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.							
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>309 Potomac St</i>					
14. FATHER'S NAME <i>John Brewer</i>				First		Middle		Last		15. MOTHER'S MAIDEN NAME <i>Virginia Russell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>No</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>577-10-8173A</i>		17. INFORMANT <i>Son</i>		17a. ADDRESS <i>309 Potomac St. Rockville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1. Arterial embolism</i> <i>185x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2. Intractable septicaemia from urinary tract</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3. Prosthetic hypertrophy + calcific prosthesis - 3 years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, OR CONDITION GIVEN IN PART 1 (c) <i>177x Prosthetic carcinoma from urinary tract obstructive + undraining</i>													
19a. DATE OF OPERATION <i>Only cystoscopy - June 1967</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year _____ <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19____, to <i>January 6, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan. 5</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>W. A. Linticum, M.D.</i>								22c. DATE SIGNED <i>1/6/68</i>		22d. PHYSICIAN'S NAME (Type) <i>W. A. Linticum</i>		22e. ADDRESS <i>1105 Washington St. Towson, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR <i>JAN 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01027

OFFICE OF THE

01027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01088									
01086									
1. DECEASED-NAME (Type or print)			First Middle Lost			2a. DATE OF DEATH			2b. HOUR
Carrie			MAY			Brooks			1 - 3 - 68 95 ^P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
F		Col		5/5/1896		71 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Miss.		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
90 Wheaton, Md.			University Nursing Home			Maid			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
47 Del. DC			V		Wash., DC.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		916 Quincy St. N.W.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Lost			First Middle Lost						
Hudson			BELL			JOHNIE HORTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			579-40-1123		hosp. Record.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gangrene</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 260X									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> , 19 <u>67</u> , to <u>1/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/5/67</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Walter G. Gooch</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/3/68</u>			
22d. PHYSICIAN'S NAME (Type) WALTER GOOCH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		1-8-67		LINCOLN mem.		SUITLAND, Ind.			
24. FUNERAL DIRECTOR <u>Seizem Funeral Home</u>				ADDRESS <u>389 Rock Island Ave. Balt.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

88010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01089				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01087					
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) Dorothy				First Brasius				2a. DATE OF DEATH Month JAN Day 14 Year 68				2b. HOUR 6:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-1-03				6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Barthonsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10 East Diamond Ave					
14. FATHER'S NAME First James P. Middle Gott Last Gott		15. MOTHER'S MAIDEN NAME First Leah Middle Atwell Last Atwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Daughter - J. Magruder Address 14206 St. Wood Drive Rockville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, massive, bilateral, with abscess formation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 303.2 (b) Chronic Bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Ethanolism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 29 mos. 10 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3. Hip - Fracture Hepar + Hepatic Insufficiency													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 60 , to 1/14 , 19 68 , that (I) (we) last saw the deceased alive on 1/14/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Stephen N. Jones, MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/15/68			
22d. PHYSICIAN'S NAME (Type) Stephen N. Jones, MD		22e. ADDRESS Rockville, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1-16-68		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City or Town) Washington, D.C.		(County)		(State)			
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR JAN 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

01083

CRIMINAL RECORDS

01083

RECEIVED BY
FBI NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Ball notified and approved

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 7a Film G397 1/25/68 kk CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR AM
First		Middle		Last		Month		Day	
Benjamin		Napoleon		Brown		January		12	
Year		1968		11:50					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		7 August 1893		74		MONTHS	
								DAYS	
								HOURS	
								MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center		Insurance Broker		Realty Ins.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3803 Brightview Street	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Louis		W.		Brown		Juliet		Doughty	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address					
No		577-05-8601		The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								Years	
IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Arteriolosclerotic Heart Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
--					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/>								County	
at work <input type="checkbox"/> at work <input type="checkbox"/>								State	
22a. I certify that (I) (this hospital) attended the deceased from January 22, 1968, to January 12, 1968, that (I) (we) last saw the deceased alive on January 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
James J. Nordlund MD								12 January 1968	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
James J. Nordlund, MD						The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		1/15/68		Cedar Hill Cemetery		Suitland		Maryland	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
S. Glen Carter Warner E. Pumphrey Inc.						JAN 18 1968		J. Charles Judge	

11010

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1186

01089 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G397 1744685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01089

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Frances Imrie				Brown				Month Day Year		9:52 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Fe.	W.	17 March 1877		91 YRS.		MONTHS DAYS		HOURS MIN		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR	
Illinois		U.S.A.		WIDOWED		DIVORCED		Montgomery		9:52 AM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		Carrall Hall Nursing Home		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Montgomery		Kensington		No		3920 Baltimore Street			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
John Imrie		John Imrie						Margaret Allen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		4218 Glenridge St.		Kensington, Md.			
No		Unknown		Walworth Brown							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary Insufficiency -										17 hrs.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Shock from falling										17 hrs.	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Arteriosclerosis Generalized -										years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9027											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
4 P.M. Jan 10 1968				Fall out of bed -							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Nursing Home				Kensington - Montgomery Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
JOHN G. BALL				ADDRESS (Street, city, town, or county)				Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Cremation		1-15-68		Cedar Hill Crematory		Suitland, Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE JAN 15 1968		Charles Judge			

01001

01001

JAN 15 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-3-64
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Ida		Middle (Addie)		Last Adella Brown		2a. DATE OF DEATH 1 Month 7 Day 68 Year		2b. HOUR 1.30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 6, 1875		6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 97 Hill Rd.			
14. FATHER'S NAME Martin Van Buren		First Middle Last Garrick		15. MOTHER'S MAIDEN NAME Mary E. Dennison		First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		(If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. no		17. INFORMANT Clayton H. Brown 4318 Delmar Ave. Marlow Hgt					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4221</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 8, 1959</u> , to <u>Jan 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William Brainin</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/7/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>						22e. ADDRESS <u>6056 Central Ave. Capitol Hill Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-9-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>					
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u>						ADDRESS <u>4308 Suitland Rd. Suitland Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

09010

686 J. E. HALL

Figure 1. A schematic diagram of the experimental setup. The subject is seated in a chair, viewing a video screen. The screen displays a target (a small circle) and a starting point (a larger circle). The subject's hand is positioned at the starting point. The distance between the starting point and the target is 10 cm. The subject is instructed to move their hand from the starting point to the target. The video screen is positioned 40 cm from the subject's hand. The subject's hand is positioned at the starting point. The distance between the starting point and the target is 10 cm. The subject is instructed to move their hand from the starting point to the target. The video screen is positioned 40 cm from the subject's hand. The subject's hand is positioned at the starting point. The distance between the starting point and the target is 10 cm. The subject is instructed to move their hand from the starting point to the target. The video screen is positioned 40 cm from the subject's hand.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01093 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 1 & 14 Film G397 1/24/68

01091

1. DECEASED-NAME (Type or print) First Middle Last ORPHA EDNA BRULEE			2a. DATE OF DEATH Month Day Year 1 11 68			2b. HOUR 7A M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 28, 1884		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY CO. Md					
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOKHAVEN CONV. HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GOVT. WORKER			12b. KIND OF BUSINESS OR INDUSTRY TEACHING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY PRINCE GEORGE'S			13c. CITY OR TOWN MT. RANIER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4010 - 32nd ST	
14. FATHER'S NAME First Middle Last AARON BRULEE			15. MOTHER'S MAIDEN NAME First Middle Last MARY MOORE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 220-54-0380			17. INFORMANT Address MRS. LEILA BRODIE 4008-32 St. Mt. RANIER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic, Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>442X</u> (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>1/11/68</u> , that (I) (we) last saw the deceased alive on <u>1/11/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Chas H. Wolcott</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Chas H. Wolcott						22e. ADDRESS 1401 Blue Rd NW					
23a. BURIAL, CREMATION, REINTERMENT BURIAL			23b. DATE 1-18-1968			23c. NAME OF CEMETERY OR CREMATORY Narmony Memorial Cem			23d. LOCATION (City or Town) (County) (State) Landover Prince Georges Md.		
24. FUNERAL DIRECTOR W.W. Chamber C 1400 Chapin St NW, D.C. DATE JAN 18 1968											

10010

10010

10010

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01092	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <u>Evelyn Mae Bullock</u>			First <u>LENA</u> Middle <u>MAY</u> Last <u>BULLOCK</u>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <u>1</u> Day <u>25</u> Year <u>1968</u>			2b. HOUR <u>M</u>		
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>33</u> YRS		6. AGE (in years last birthday) <u>33</u> MONTHS <u></u> DAYS <u></u>		7c. DATE PRONOUNCED DEAD <u>JAN 25</u> Year <u>1968</u>		2d. HOUR <u>7:5</u> M	
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u>			Md.		
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wash. San. Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>PR GEO Langley Park</u>			13c. CITY OR TOWN <u>YES</u> <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <u>8016 1/2 14th Ave.</u>		
14. FATHER'S NAME First <u>Andrew</u> Middle <u>Bullock</u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>Carrie</u> Middle <u>Bullock</u> Last <u></u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>466x</u> IMMEDIATE CAUSE (a) <u>Acute, severe, purulent</u> DUE TO, OR AS A CONSEQUENCE OF <u>bronchitis and bronchiolitis</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>500x</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u></u> P.M. <u></u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Reap</u>			M.D. <u></u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>JAN. 25, 1968</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>			ADDRESS <u>Washington, D.C.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>1/27/68</u>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) <u>Richmond, Virginia</u>		
24. FUNERAL DIRECTOR <u>Fraziers Funeral Home,</u>			ADDRESS <u>Washington, D.C.</u>			25a. REC'D BY REGISTRAR <u>JAN 31 1968</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

01034

01034

1944 JAN 14

From: [illegible]
To: [illegible]
Subject: [illegible]

[Faint, mostly illegible text in the main body of the document, possibly a letter or report.]

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
010935									
CERTIFICATE OF DEATH									
01093									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.M.
Bertha			O. Burdette			January 28, 1968			3:20
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Nov. 28, 1886		81		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Germantown		RFD # 2		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Germantown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD # 2	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Asbury Mullinix			Elizabeth O. Bowman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
No		215-36-4661		Paul D. Burdette, Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm of left kidney, type unknown,</u> <u>1890</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Arteriosclerosis Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pyohydronephrosis</u> <u>10 years?</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>app. 1 year.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>180X</u> <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None. Had		Cystoscopy & Retrograde		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21c. LOCATION Street or R.F.D. No. City or Town County State					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
None		No injury.		No accident.					
22a. I certify that (I) this hospital attended the deceased from <u>1935</u> , 19 <u> </u> , to <u>January 28, 1968</u> , that (I) (we) <u>we</u> saw the deceased alive on <u>January 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. McKendree Boyer, M.D.</u>			22c. DATE SIGNED <u>January 29, 1968</u>						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
M. McKendree Boyer, M.D.			9701 Church Street Damascus, Maryland.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 31, 1968		Damascus Meth.		Damascus, Md.			
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, Damascus, Md.			FEB 2 1968			<u>Charles Judge</u>			

01003

RECEIVED - DEATH

01003

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Name of informant: [illegible]
6. Address of informant: [illegible]
7. Signature of informant: [illegible]
8. Date of report: [illegible]
9. Name of official: [illegible]
10. Signature of official: [illegible]
11. Date of filing: [illegible]
12. Name of agency: [illegible]
13. Address of agency: [illegible]
14. Telephone number: [illegible]
15. File number: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Robert Lee Burkett					2a. DATE OF DEATH Jan 29 1968			2b. HOUR 545 M	
3. SEX M		4. RACE W.		5. DATE OF BIRTH 5/15/85		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1161 Ridge Rd Wash. G.	
14. FATHER'S NAME First Samuel Middle M. Last Burkett		15. MOTHER'S MAIDEN NAME First Mary Middle Myers Last Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-05-2635		17. INFORMANT daughter		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Spontaneous years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4200									
19a. DATE OF OPERATION 5/6/67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED insertion of Cardiac Pacemaker		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/26 , 1968, to 1/30 , 1968, that (I) (we) last saw the deceased alive on 1/29 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.T. Benack MD DEGREE MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/29/68			
22d. PHYSICIAN'S NAME (Type) R.T. Benack MD				22e. ADDRESS 4115 Colie Drive, Wheaton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-1-68		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City or Town) (County) (State) Gaithersburg Montg. Md.			
24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS Gaithersburg				25. REC'D BY REGISTRAR MD DATE FEB 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

01034

01034

ESTIMATE OF DEATH

ESTIMATE OF DEATH

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Age at death: [illegible]
7. Sex: [illegible]
8. Race: [illegible]
9. Occupation: [illegible]
10. Education: [illegible]
11. Marital status: [illegible]
12. Number of children: [illegible]
13. Name of spouse: [illegible]
14. Name of parents: [illegible]
15. Name of next of kin: [illegible]
16. Name of physician: [illegible]
17. Name of funeral home: [illegible]
18. Name of cemetery: [illegible]
19. Name of burial place: [illegible]
20. Name of interment place: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Mary			BURRISS			January 8 1968		300P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		January 8, 1968		— YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			N/A		N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George Landover					13e. STREET AND NUMBER	
								1717 Bellhaven Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frederick Burriss			Flora			Dunn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
N/A			N/A			Landover, Md.			
						Mrs. Flora Burriss, 1717 Bellhaven Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Prematurity / previable</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
776 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1968, to Jan. 8, 1968, that (I) (we) last saw the deceased alive on Jan. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<i>Donald L. Taylor</i>								Jan. 12, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		1-13-68		CEDAR HILL		1000 SOUTLAND RD SE MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
B.F. Taylor				909 6th St N.W.		DATE JAN 17 1968		<i>Charles Judge</i>	

72010

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01098		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01096	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Catherine Kelsie Burton</i>			2a. DATE OF DEATH <i>January 16, 1968</i>		2b. HOUR <i>5:20 A.M.</i>
3. SEX <i>Female</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>January 24, 1904</i>		6. AGE (In years last birthday) <i>63</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. BIRTHPLACE (State or foreign country) <i>Va.</i>			9. COUNTY OF DEATH <i>MONTGOMERY Md.</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium Hosp. #swt</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>	
14. FATHER'S NAME First <i>Ben</i> Middle <i>McKenny</i> Last <i>Catherine</i>		15. MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i></i> Last <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>332 X</i>		17. INFORMANT <i>Hospital Records</i>		Address <i>7600 Carroll Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Pontine infarction</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4339</i>					
(b) <i>Atherosclerosis & Thrombosis.</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <i></i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>19</i> Day <i>19</i> Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 7, 1968</i> , to <i>JAN 16, 1968</i> , that (I) (we) last saw the deceased alive on <i>JAN 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>JAN 16, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>[Signature]</i>		22e. ADDRESS <i>[Signature]</i>			
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1/20/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ash Memorial Cem.</i>	
23d. LOCATION (City or Town) <i>Sandy Spring</i>		(County) <i>Montgomery</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>R. Snowden</i>		ADDRESS <i>Rockville</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>	
DATE <i>JAN 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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VR A15 (4)
30M REV. 1/68

01099		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01097					
CERTIFICATE OF DEATH						Coroner John Ball M.D.					
1. DECEASED-NAME (Type or print) MABEL S. BUSCHING			First Middle Last			2c. DATE OF DEATH Jan. 16, 1968 Month Day Year		2b. HOUR 3:30 P.M.			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH May 18, 1883		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4718 Bayard Blvd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4718 Bayard Blvd.			
14. FATHER'S NAME Winfield Offutt			First Middle Last			15. MOTHER'S MAIDEN NAME Mary E. Stearn			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Daughter		Address Mrs. Donald Buglass		Same as Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile Generalized Arteriosclerosis											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —		21f. LOCATION Street or R.F.D. No. City or Town County State —							
22a. I certify that (I) (this hospital) attended the deceased from June, 1965 , to Jan 8, 1968 , that (I) (we) lost saw the deceased alive on 1-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 1-16-68											
22b. SIGNATURE P.P. Andrews M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-16-68			
22d. PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D.				22e. ADDRESS 4201 Fessenden St., N. W. WASHINGTON DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-19-68		23c. NAME OF CEMETERY OR CREMATORY Potomac Meth. Cem.		23d. LOCATION (City or Town) (County) (State) Potomac, Maryland					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY REGISTRAR JAN 24 1968		25b. REGISTRAR'S SIGNATURE Francis Judge			

01094

CERTIFICATE OF DEATH

DIVISION OF HEALTH, STATE OF NEW YORK

DATE OF DEATH

DAY, MONTH, YEAR

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

NAME

DATE

TIME

PLACE

CAUSE

PLACE

CAUSE

PLACE

CAUSE

PLACE

CAUSE

PLACE

CAUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
James Carroll			BYRNES			January 15 1968			615P M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	Caucasian		June 10, 1890			77 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			U.S. Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Washington, District of Columbia								2339 Massachusetts Ave. N.W.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James C. Byrnes			Louisa Dunn Cooke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes 1907-1939			579-50-3984		Navy records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>410.7</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>Jan. 15</u> , 19 <u>68</u> , to <u>Jan 15</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Jan. 15</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L W Raymond MD</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>Jan. 16, 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>L. W. Raymond, MD</u>					22e. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-18-68		Naval Academy Cemetery		Annapolis, Maryland			
24. FUNERAL DIRECTOR <u>Devol Funeral Home</u>					25a. REC'D BY REGISTRAR <u>J.E. Dwyer</u>		25b. REGISTRAR'S SIGNATURE <u>James J. J...</u>		
2222 Wisconsin Ave., N.W. Washington, D.C.					DATE <u>JAN 22 1968</u>				

01100

01000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Lillian Gertrude Cann						2a. DATE OF DEATH Month Day Year January 19 1968			2b. HOUR 11:15 a.m.			
3. SEX F		4. RACE W		5. DATE OF BIRTH May 9, 1886			6. AGE (In years lost birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home for the Aged			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Milliner			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1607 Darley Avenue			
14. FATHER'S NAME First Middle Last John Thorney				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Elizabeth Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no			16b. SOCIAL SECURITY NO. 220-54-0804			17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR 10 YRS												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 334X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 4/63 , 19__, to 1/19/68 , 19__, that (I) (we) last saw the deceased alive on 1/16/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Henry C. Scruggs DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 1/19/68						
22d. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS						22e. ADDRESS BETHESDA, MD.						
23a. BURIAL, CREMATION, or other disposition BURIAL		23b. DATE 1-22-68		23c. NAME OF CEMETERY OR CREMATORY CEORAR HILL				23d. LOCATION (City or Town) (County) (State) BALTO. MD.				
24. FUNERAL DIRECTOR Wm. J. Fickner & Sons ADDRESS Balto. Md				25a. REC'D BY REGISTRAR DATE JAN 23 1968				25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

01101

01009

William J. ...
...
...

May 2, 1946

Memorandum

Subject: ...

Reference is made to ...

Very truly yours,

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01102		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01100	
1. DECEASED-NAME (Type or print) Samuel				First Middle Last	2a. DATE OF DEATH January 22 1968		2b. HOUR 11:10 P.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-24-1891		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 107 Dawson Ave.	
14. FATHER'S NAME Unknown				15. MOTHER'S MAIDEN NAME Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-09-5351		17. INFORMANT Clara R. Caponera-Item# 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 188X <u>uric acidosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bladder infection</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 mos. 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 181.0 <u>Carcinoma of Bladder + Cholelithiasis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this-hospital) attended the deceased from 1/16, 1965, to 1/24, 1968, that (I) (we) last saw the deceased alive on 1/22, 1968, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen N. Jones		22c. DATE SIGNED 1/23/68		22d. PHYSICIAN'S NAME (Type) Stephen N. Jones			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/26/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR DATE JAN 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

01100

01100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01103		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01101	
Item 6 Film G396 1/16/68 kk		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR	
HARRY CARPENTER			JAN 5 1968			3:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		white		4-13-1888		184 yrs.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		US				MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
KENSINGTON		KENSINGTON GARDENS SANIT.		Coal Miner		Mining	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		WASHINGTON		Hagerstown			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last				
Unknown			Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes, na, or unknown)		---		Kensington Gardens -Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 411.9 Cardiac arrest							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary insufficiency serv. l.ys.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9/18, 1967, to Jan 5, 1968, that (I) (we) lost saw the deceased alive on Jan 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
Marvin Wadler M.D.		1/5/68		MARVIN WADLER			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
		8218 Wisc. Av. - Beth. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Cremation		1/8/68		Cedar Hill		Prince George Co. Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home-1331 Rockville Pike		Pike		JAN 10 1968		J. Charles Judge	
Rockville, Md.							

01101

01101

CERTIFICATE OF DEATH

BB

UNKNOWN

UNKNOWN

Investigation of death -

1912

1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01104					01102				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Ellen</i>			First Middle Last <i>M. Carroll</i>		2a. DATE OF DEATH Month Day Year <i>JAN. 28 1968</i>			2b. HOUR <i>1:55</i> A M	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2/3/88</i>		6. AGE (In years lost birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley N. H.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7812 Tilbury St.</i>	
14. FATHER'S NAME First Middle Last <i>John Daugherty</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>578-10-2497</i>		17. INFORMANT <i>Son</i>		Address <i>Same as Item 13.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebrovascular thrombosis</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>332X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1966</i> , to <i>1-28, 1968</i> , that (I) (we) lost saw the deceased alive on <i>1-18</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V. J. Bucy / S. W. Jones</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>D. L. / Bucy</i>		22e. ADDRESS <i>809 Veirs Mill Rd MONT. Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-1-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE
HEALTH DEPT.

01105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01103

1. DECEASED-NAME (Type or Print)		First Gilmer		Middle F.	Last Carter		20. DATE KNOWN OF ESTI- DEATH MATED		<input type="checkbox"/> Month <input checked="" type="checkbox"/> 1	Day 7	Year 1968	2b. HOUR p. 58			
3. SEX M	4. RACE W	5. DATE OF BIRTH 3/7/05		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month January 7		Day 19	Year 1968	2d. HOUR M	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.									
1d. CITY OR TOWN OF DEATH Silver Spring,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/>		13e. STREET AND NUMBER 722 Richmond Ave.					
14. FATHER'S NAME First ALEXANDER				Middle BRYANT		Last NOT AVAILABLE		15. MOTHER'S MAIDEN NAME First NOT AVAILABLE				Middle NOT AVAILABLE		Last NOT AVAILABLE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 233 18 6761		17. INFORMANT ADDRESS MISS MARGARET A. CARTER (SAME AS 13c)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute severe pneumonitis</u> <u>486x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Heart Disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>482x</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my apinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Read, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Post city and county) Wheaton				22b. DATE SIGNED JAN. 8, 1968							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Folk Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md.									
24. FUNERAL DIRECTOR Address Tolman Funeral Home, J. A. Waters, 254 Carroll				25a. READ BY REGISTRAR DATE JAN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01106

Item 6 Film G397 2/7/68 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01104

1. DECEASED NAME (Type or print) Bernadette		First Cardin		Middle Cheek		Last		2a. DATE OF DEATH Jan Month Jan Day 27 Year 1968		2b. HOUR 9:00 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec 19 1911		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Minasota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5912 Rudyard		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5912 Rudyard Drive			
14. FATHER'S NAME Louis		First F		Middle Cardin		Last		15. MOTHER'S MAIDEN NAME Bertha		First Sandvick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, not unknown No		(If yes give war or dates of service) none		16b. SOCIAL SECURITY NO. 220-09-2780		17. INFORMANT Vernon R Cheek		Address 5912 Rudyard Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Breast APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos 2 yrs 4 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Osteo-metastases & Dr. of H. Hip											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/2, 1968 , to 1/26, 1968 , that (I) (we) last saw the deceased alive on 1/26, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen Jones		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/29/68					
22d. PHYSICIAN'S NAME (Type) Stephen Jones		22e. ADDRESS 809 Veirs Mill Rd Rockville, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-31-68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Mont. Md					
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin AVE Bethesda, Md		25a. REC'D BY REGISTRAR DATE FEB 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01107					01105				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
DOROTHY			LOUISE	CHEW	Month 1 Day 7 Year 68			2:21a.M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		1/28/22		45 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Olney			Montgomery General			Wired & Assembler			Communic. Electronics
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Frederick		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #4	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Charles			Colson	Mattie	Fisher				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
no			219-03-2599		Montgomery General Hosp. Olney Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation / hour</u>									
410.9 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction / wk</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
					63 1/7 68				
22a. I certify that (I) (this hospital) attended the deceased from 1963, to 1/7, 1968, that (I) (we) lost the deceased alive on 1/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Charles H. Ligon, M.D.									1/7/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Charles H. Ligon, M.D.		Medical Center, Sandy Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/10/1968		Morgan Chapel		Carroll Co., Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
C. M. Waltz, Box 241, Sykesville, Md.					JAN 10 1968		O'Connell Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

01108										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01106																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last Ada E. Clark										Month 10 Day 68 Year										9 A.M.																																							
3. SEX F										4. RACE White										5. DATE OF BIRTH June 18, 1875										6. AGE (In years last birthday) 92 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) WASH. D.C.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																													
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Retired-Sect. U.S. Gov't.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Montgomery										13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 2016 Hanover Street Silver Spring																			
14. FATHER'S NAME First Middle Last William P. Clark										15. MOTHER'S MAIDEN NAME First Middle Last Sally P. Richardson																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-24-1258										17. INFORMANT 13203 Karadane Alice Reynolds Silver Spring, Maryland																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Pneumonia, Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) ASHD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) 4200																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1967, to Jan 10, 1968, that (I) (we) lost saw the deceased alive on Jan 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																																																											
22b. SIGNATURE Fred A. Gill M.D.										22c. DATE SIGNED Jan. 10/1968																																																	
22d. PHYSICIAN'S NAME (Type) FRED A. GILL, M.D.										22e. ADDRESS 4743 BRADLEY BLVD CITY MD																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 13, 1968										23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery										23d. LOCATION (City or Town) (County) (State) Washington, D.C.																													
24. FUNERAL DIRECTOR Glen Carter										25a. REC'D BY REGISTRAR DATE JAN 15 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																																							
Warner E. Pumphrey, Inc.										8434 Georgia Ave. Silver Spring, Md.																																																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN lb <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> <u>4011 Randolph Road Wheaton Md-</u>					d. STREET ADDRESS <u>3817 Warren St. N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jessie S. Caggins</u>					4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1968</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-1874</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William MacKenzie</u>					14. MOTHER'S MAIDEN NAME <u>Mary Jane Burnside</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary V. Townsend 3930 Conn. Ave. N.W.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>with congestive failure.</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4200</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>67</u> , to <u>1/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> 19 <u>68</u> , and that death occurred at <u>1:45 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>S. W. Nealon Jr</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/8/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.W. Nealon, Jr.</u>						22d. ADDRESS <u>1746 K St. N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1/11/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		
24. FUNERAL DIRECTOR <u>Mr. S. H. Davis</u>						ADDRESS <u>2901-14</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 12 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Mr. S. H. Davis</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01110				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01108			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Cornie J. Coleman						2a. DATE OF DEATH 1 Month 24 Day 68 Year		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-20-00		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) No. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont.			13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4510 Adrian Street	
14. FATHER'S NAME First Middle Last Henry				15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 071 03 5611		17. INFORMANT Don Clyde Coleman				Address -same item # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperventilation 492x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5921 (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchogenic Carcinoma, Bronchopneumonia, Bronchiectasis and Pleural Effusion											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from Sept 1967 to 1/24/68 , that (I) (we) lost saw the deceased alive on 1/23/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert C. Macon				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/24/68			
22d. PHYSICIAN'S NAME (Type) Robert C. Macon				22e. ADDRESS 809 Veirs Mill Road, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/27/68		23c. NAME OF CEMETERY OR CREMATORY Beries Creek Cemetery				23d. LOCATION (City or Town) (County) (State) North Carolina			
24. FUNERAL DIRECTOR TYSON WHEELER FUNERAL HOME						ADDRESS 1331 Rock Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE JAN 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01109

Conner

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Conner</u>		First <u>Hugh</u> Middle <u>B.</u> Last <u>Conner</u>		2a. DATE OF DEATH Jan Month 20 Day 68 Year		2b. HOUR 439 M	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Jan 27, 1898</u>		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>CHERRY CHASE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bethesda Silver Spring Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Real Estate Broker</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>WASH. DC.</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Washington</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>2815 28th St. N.W.</u>		14. FATHER'S NAME First <u>Alfred</u> Middle <u>Conner</u> Last <u>Elizabeth</u>		15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>Cary</u> Last <u>Cary</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>		16b. SOCIAL SECURITY NO. <u>578-01-8054A</u>		17. INFORMANT <u>John R. Conner</u>		Address <u>869 N. Jefferson St. Arlington, VA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cerebral Vascular Accident</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>260x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>1/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Lennard Gold</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/20/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>				22e. ADDRESS <u>8641 Colesville Rd. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>24 JAN 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawkens Sons</u>				ADDRESS <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared E Med. Examiner 1/26/68

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RECORDS OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Christine</i> First <i>Frisz</i> Middle <i>CONRAD</i> Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Jan</i> Day <i>10</i> Year <i>1968</i>		2b. HOUR <i>9:30</i> M
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>July 18, 1886</i>	6. AGE (In years last birthday) <i>81</i> YRS.	7c. DATE PRONOUNCED DEAD <i>Jan 10</i> Month <i>Jan</i> Day <i>10</i> Year <i>1968</i>
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>5701 River Road</i>
14. FATHER'S NAME <i>Peter Fresz</i> First <i>Peter</i> Middle <i>Fresz</i> Last	15. MOTHER'S MAIDEN NAME <i>Christine Bauilles</i> First <i>Christine</i> Middle <i>Bauilles</i> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter</i> ADDRESS <i>Cecilia Conrad - add. same</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>890X</i> (b) <i>Smoke Inhalation and Carbon monoxide poisoning</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Conflagration (Fire) in Apartment</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>minutes</i> <i>minutes</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9160</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year <i>9:15 P.M. Jan 10 19 68</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Soft caught fire cause not determined</i>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Apartment Bldg.</i>	21f. LOCATION Street or R.F.D. No. <i>5701 River Rd.</i>	City or Town <i>Bethesda</i>	County <i>Montgomery</i> State <i>Md.</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>Jan. 11, 1968</i>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-13-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City or Town) <i>Terre Haute, Indiana</i>	(County) (State)
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>JAN 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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NOTAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

011113										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										011111																			
1. DECEASED-NAME (Type or print) First Margaret C. Middle Coughlin										2a. DATE OF DEATH Month January Day 17 Year 1968										2b. HOUR M																			
3. SEX Female					4. RACE White					5. DATE OF BIRTH April 5, 1911					6. AGE (In years last birthday) 56					IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) Tennessee					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery																								
10. CITY OR TOWN OF DEATH Silver Spring					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4309 Havard Street					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waitress					12b. KIND OF BUSINESS OR INDUSTRY																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 4309 Havard St.																			
14. FATHER'S NAME First James Middle Clark					15. MOTHER'S MAIDEN NAME First Grace Middle Kelly																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 279-16-1493					17. INFORMANT Grace Johnson - daughter										Address																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) A SHD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Years																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Irreversible uremia - Rubella malaris																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1968 , to Jan 17, 1968 , that (I) (we) last saw the deceased alive on Jan 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Richard P. DeLaney										DEGREE Raymond T. Benack										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) Richard P. DeLaney										22e. ADDRESS Raymond T. Benack 4323 Havard St. Silver Spring																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 1/20/68					23c. NAME OF CEMETERY OR CREMATORY North Jackson Cemetery					23d. LOCATION (City or Town) (County) (State) Ohio																								
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home										ADDRESS 1331 Rock Pike										25a. REC'D BY REGISTRAR DATE JAN 19 1968										25b. REGISTRAR'S SIGNATURE Charles Judge									
										Rockville, Md.																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
011114					011112				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
GRACE EDNA COVO					Month JAN Day 26 Year 68			1:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		3/26/1896		71 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, DC						MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			SUBURBAN			Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
MONTGOMERY			Washington, DC					STRATFORD HOTEL	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Elisha P. Taylor			Grace E. Mockbee						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			no			Oscar T. Williams 16 Montrose Manor Ct Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive heart failure									
DUE TO, OR AS A CONSEQUENCE OF									
(b) arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Bronchopneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1965, 19, to 26 JAN, 19 68, that (I) (we) lost saw the deceased alive on 26 JAN 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
WALTER GOOZT MD									
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
WALTER GOOZT MD					2309 SHOREFIELD RD WHEATON MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/29/68		Cedar Hill Cemetery		Prince Georges Co. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
The H. Heins Co. 2901 14th St. N.W.					JAN 30 1968		Charles Judge		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01115
Items 16b, 17 & 23b

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01113

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH ESTI-MATED		Month	Day	Year	2b. HOUR		
<i>Faith Abigail Crocker</i>								<i>Jan 10 1968 9³⁰M</i>		<i>Jan</i>	<i>10</i>	<i>1968</i>	<i>9³⁰M</i>		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR			
<i>F</i>	<i>white</i>	<i>Dec 19 1914 53</i>		<i>53</i>						<i>Jan 10 1968 9³⁰M</i>		<i>9³⁰M</i>			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
<i>MASS.</i>		<i>U.S.</i>				<i>Montgomery</i>						<i>Md</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
<i>Bethesda</i>		<i>Lutheran</i>		<i>HOUSE WIFE</i>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
<i>Maryland</i>		<i>Montgomery</i>		<i>Rockville</i>				<i>307 Claydon Drive</i>							
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last													
<i>Charles H. Wilson</i>		<i>Mary D. Brewer</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Husband ADDRESS											
<i>No</i>		<i>Unknown</i>		<i>Sabine Crocker, Jr.</i>		<i>Same as Item 13.</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, old and acute</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis, old and recent</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Advanced coronary arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>4201</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS(Street, city, town, or county) <i>Bethesda, Md.</i> ACTUAL SIGNATURE <i>John G. Ball</i> M.D. 22b. DATE SIGNED <i>Jan 11, 1968</i> EXAMINER'S NAME (Type) JOHN G. BALL															
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>1-13-68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Wollaston Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Quincy, Mass.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>								25a. REC'D BY REGISTRAR <i>JAN 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>V. Chas. N.</i>					

TO : [illegible]
FROM : [illegible]
SUBJECT : [illegible]
DATE : [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum detailing a project or administrative matter.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

011114

011116		1. DECEASED-NAME (Type or print)		First <i>Katie</i>	Middle <i>(Nmi)</i>	Lost <i>Culotta</i>	2a. DATE OF DEATH Month <i>1</i>		Day <i>30</i>	Year <i>68</i>	2b. HOUR <i>10:5 PM</i>
3. SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4/5/98</i>		6. AGE (In years lost birthday) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS <i>69</i>		IF UNDER 24 HRS. DAYS <i>69</i>	
7a. BIRTHPLACE (State or foreign country) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9743 Hedin Drive</i>			
14. FATHER'S NAME First <i>Michael</i>		Middle <i>Bellopanni</i>		Lost <i>Josephine Scacelo</i>		15. MOTHER'S MAIDEN NAME First <i>Josephine Scacelo</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-40-1579D</i>		17. INFORMANT <i>Rosario Gloriano</i>		Address <i>9743 Hedin Drive Silver Spring, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5739</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hepatic Coma</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>583X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>30 Jan</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>30 Jan</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dra N. Tublin</i>		22c. DATE <i>1/30/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Dra N. Tublin</i>		22e. ADDRESS <i>800 Pershing Drive, Silver Spring, Md.</i>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 3, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring Maryland</i>		23e. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
23f. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>		23g. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		23h. REC'D BY REGISTRAR DATE <i>FEB 5 1968</i>		23i. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) OPHELIA Catherine CURRY					2a. DATE OF DEATH Month 01 - Day 31 - Year 68			2b. HOUR 4:10 ^{PM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 6-11-84		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 25 E. Wayne Ave. Apt. 514	
14. FATHER'S NAME First JOHN Middle McCauley Last Swanson		15. MOTHER'S MAIDEN NAME First Mary Middle Swanson Last Swanson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 230-70-8653		17. INFORMANT Hospital Records		Address 7600 Carroll Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Heart Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ yrs 10+ yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diverticulitis, multiple CVAS, Hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, etc.) Office Building, etc.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 15 , 1966, to Jan 31 , 1968, that (I) (we) lost saw the deceased alive on Jan 30 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. H. Sandstrom M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-31-68			
22d. PHYSICIAN'S NAME (Type) R. H. Sandstrom M.D.		22e. ADDRESS 7701 Carroll Ave Takoma Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Feb. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Harrodsburg Rockingham Va			
24. FUNERAL DIRECTOR Sandstrom Funeral Home		ADDRESS Harrodsburg Va		25a. REC'D BY REGISTRAR Represented by A.M. DAY		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 2 1968	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First AMELIA			Middle —			Last DACY			2a. DATE OF DEATH Month Day Year JAN 16 68			2b. HOUR M		
3. SEX FEMALE			4. RACE White			5. DATE OF BIRTH 3-15-1900			6. AGE (In years lost birthday) 67 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) LEBANON			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.								
10. CITY OR TOWN OF DEATH Silver Spring, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington			13b. COUNTY D.C.			13c. CITY OR TOWN ✓			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1531 Upshur St.					
14. FATHER'S NAME First Middle Last NORMAN KOTOL			15. MOTHER'S MAIDEN NAME First Middle Last ALMAS SHAKER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No						16b. SOCIAL SECURITY NO. 577-56-0138A			17. INFORMANT Address Edward Dacy-13319 Foxhall Dr. Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1829 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulvic Abscess (c) Adenocarcinoma of uterus DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months 3 1/2 yrs																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 174X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1968, to 1/16, 1969, that (I) (we) last saw the deceased alive on 1/16/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE G. Lennard Gold			22c. DATE SIGNED 4/17/68			22d. PHYSICIAN'S NAME (Type) G. Lennard Gold			22e. ADDRESS 8641 Colesville Rd. S. Spg. Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1/19/68			23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.								
24. FUNERAL DIRECTOR The S.H. Hines Co. 2901-14th St.			25a. REC'D BY REGISTRAR DATE JAN 22 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

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RECEIVED

6000 California St. S.F. 94118

6000 California St. S.F. 94118

RECEIVED

Cleared with Dr. Keap

Deputy Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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011119										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										011117									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Edward H. Davidson										1 Month 15 Day Year 68										4:30 PM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost birthday)					IF UNDER 1 YEAR MONTHS					IF UNDER 24 HRS. HOURS MIN.				
male					white					9-26-1882					85 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Conn.					U. S.										Montgomery Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Takoma Park					Wash. San + Hosp Dir. - ICC										U.S. Govt														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Montgomery					Silver Spring					YES					514 Alfred Dr.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
Edward Davidson					Jessie Smith																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT																			
No					579-60-9370					Mrs. Anita Autry - dgt.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) 410.9										CORONARY Thrombosis										Sudden									
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) CORONARY ARTERY Disease										5 YRS.									
DUE TO, OR AS A CONSEQUENCE OF										(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
4201																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1-14, 1959, to 1-15, 1968, that (I) (we) lost saw the deceased alive on 1-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE					DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
HERBERT L. TANENBAUM															1/15/68														
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																								
HERBERT L. TANENBAUM					4400 Conn. Ave NW Wash DC																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					1-19-68					Gate of Heaven Cem.					Silver Spring, Maryland														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
ROBERT A. PUMPHREY, Bethesda, Maryland										JAN 24 1968										Charles Judge									

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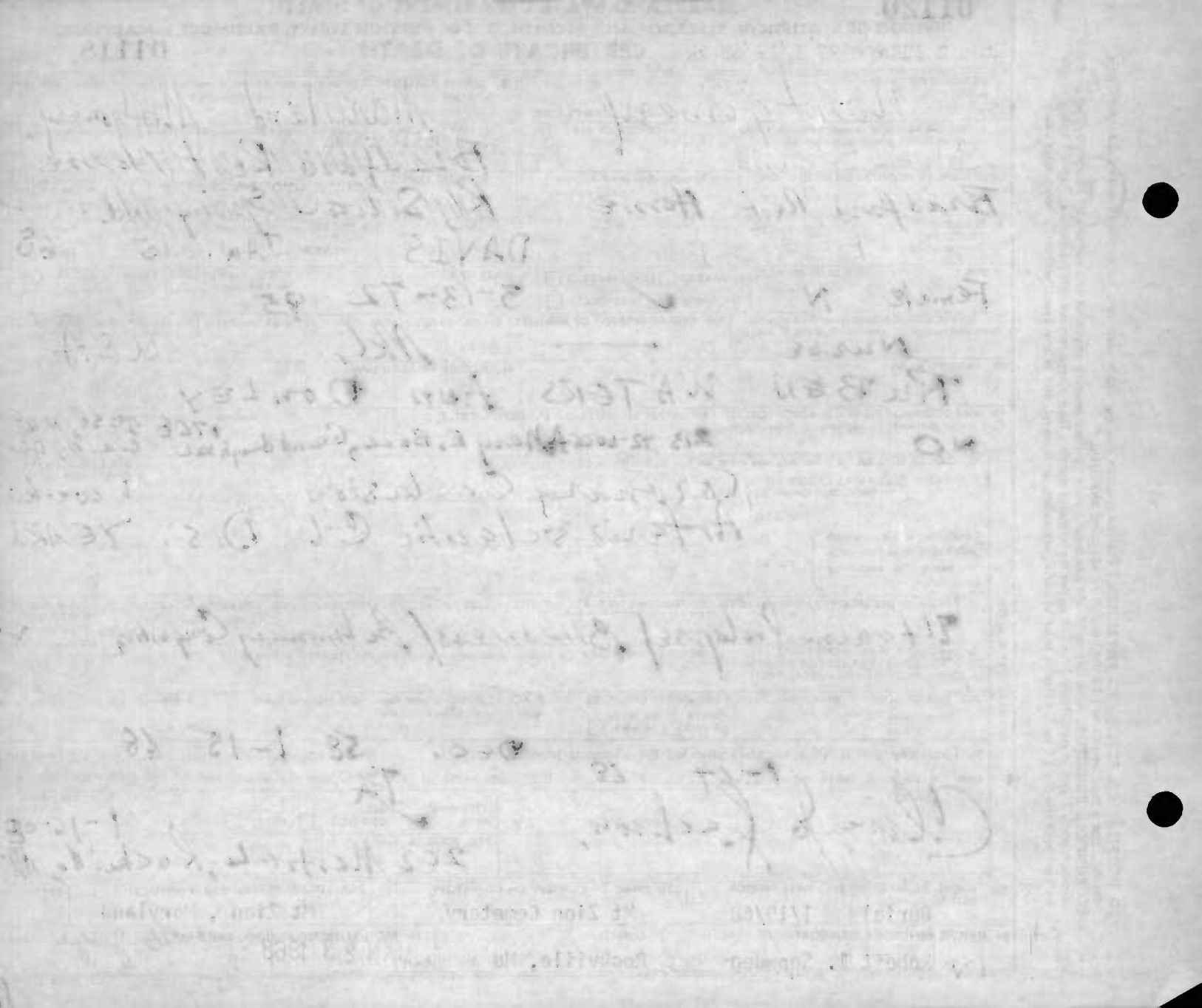
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01120</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div>											
Item 2 Film G397 1/29/68 kk						CERTIFICATE OF DEATH			01118		
1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bradford Rest Home</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bradford Rest Home</i>						d. STREET ADDRESS <i>Emory Grove Rd. Killebrew Spring, Md.</i>					
3. NAME OF DECEASED (Type or print) <i>BETSY</i>						4. DATE OF DEATH <i>DAVIS JAN. 15 1968</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-13-72</i>		9. AGE (In years last birthday) <i>95</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>RUBEN WATERS</i>						14. MOTHER'S MAIDEN NAME <i>ANN DONLEY</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>						16. SOCIAL SECURITY NO. <i>213-42-6005</i>					
						17. INFORMANT <i>Mary E. BELL, Grand daughter</i> Address <i>1708 5th St. N.W. Wash, D.C.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> (b) <i>Arterio sclerotic C-V Dis.</i> (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <i>4201</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Uterine Prolapse/ Blindness/ Pulmonary Congestion</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>1 week YEARS</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>DEC. 58</i> to <i>1-15-68</i> , that (I) (we) last saw the deceased alive on <i>1-14</i> 19 <i>68</i> , and that death occurred at <i>7:00</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Clive J. Jackson</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-16-68</i>			
22c. PHYSICIAN'S NAME (Type) <i>Clive J. Jackson</i>						22d. ADDRESS <i>202 Mastin Ln, Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/19/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Mt Zion, Maryland</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i> ADDRESS <i>Rockville, Md</i>						25a. REC'D BY REGISTRAR <i>JAN 23 1968</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			



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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
011121					011119				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First <i>Lorence</i> Middle <i>E.</i> Last <i>Sellinger</i>					2a. DATE OF DEATH Month <i>January</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>3 P</i> M	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>9-24-80</i>		6. AGE (in years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Seaboard</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3345 Years Bridge Road</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Painter</i> Last <i>Painter</i>			15. MOTHER'S MAIDEN NAME First <i>Lillian</i> Middle <i>Quaker</i> Last <i>Quaker</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs. Sister, (ERMA R.)</i>		Address <i>Above (daughter)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i> (b) <i>Advanced coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i> <i>years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>Adynamic ileus due to mesenteric artery stenosis due to arteriosclerosis.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>66</i> , to <i>Jan</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Jan 14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Marvin Wadler</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>1/17/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER</i>					22e. ADDRESS <i>8218 Wisc. Ave. Belh. Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1-17-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Wood Cemetery</i>		23d. LOCATION (City or Town) <i>Edenburg, Va.</i> (County) (State)			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> ADDRESS <i>5130 Wisc. Ave. N.W. Wash. D.C.</i>					25a. REC'D BY REGISTRAR <i>JAN 22 1968</i> DATE		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

01110

01110

LEFT BRANCH OF STREAM

Handwritten notes and sketches, including a small diagram of a stream branching into two paths. The text is mirrored across the page.

Large section of mirrored handwritten text and faint sketches, possibly representing a map or a detailed description of a landscape. The text is mostly illegible due to the mirroring effect.

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VR 151 (4)
30M REV. 1/68

01122		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01120	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>JAMES B. DE MENT</u>			2a. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1968</u>			2b. HOUR <u>12:28</u> AM	
3. SEX <u>male</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>July 11, 1881</u>		6. AGE (If years lost birthday) <u>86</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <u>FRANK DE MENT</u>		15. MOTHER'S MAIDEN NAME <u>MARY STARBUCK</u>		13e. STREET AND NUMBER <u>12329 Charles Rd.</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>471X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Influenza</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>470X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Emphysema</u> <u>ARTERIOSCLEROTIC Heart Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>1/7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Raymond T. Bernack</u>				22c. DATE SIGNED <u>1/7/68</u>		22d. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BERNACK</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1/10/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MD.</u>	
24. FUNERAL DIRECTOR <u>JAS. T. RYAN, INC.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>William D. ...</u>	

05110

RECEIVED BY LEAD

05110

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01123

01121

1. DECEASED-NAME (Type or print) Grace Devendorf			2a. DATE OF DEATH Month Day Year January 16 1968			2b. HOUR 3:15 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH November 9, 1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium and Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9032 Piney Branch Road		
14. FATHER'S NAME First Middle Last Harry Devendorf			15. MOTHER'S MAIDEN NAME First Middle Last Anna Wright								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 577-111-3279		17. INFORMANT Address Patinet's chart						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x <u>Arteriosclerotic Vascular Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>67</u> , to <u>Jan 16</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 15</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bernard A. Fitzgerald MD</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-16-68		
22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD					22e. ADDRESS 217 UNIV. BLVD. E, SILVER SPRING, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE January 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum			23d. LOCATION (City or Town) (County) (State) Prince George, Maryland				
24. FUNERAL DIRECTOR Glen Carter, Inc. Warner E. Humphrey, Inc.					ADDRESS 2434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE JAN 22 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...		

11110

STATE OF TEXAS

11110



Handwritten text, possibly a signature or date, running vertically along the right margin.

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VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01124 CERTIFICATE OF DEATH 01122									
1. DECEASED-NAME (Type or print) <i>Jessica</i>			First Middle Last <i>N.M.N. Dewey -</i>			2a. DATE OF DEATH <i>Jan 26 1968</i>		2b. HOUR <i>1:20 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Aug-17-1878</i>		6. AGE (In years last birthday) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>h.s.wt.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>house wife</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8009 Glenside Drive</i>	
14. FATHER'S NAME First Middle Last <i>Frank Burgoe</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Martha Zimmerman</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Hosp. Records</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pen & Tachy cardiac</i> <i>428X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Brachopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pertussis & Ph. Myocarditis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>? 1/20/68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4331</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 29</i> , 19 <i>67</i> , to <i>1/26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1/25</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Howard T. House</i> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/26/68</i>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Feb. 1-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Springdale</i>		23d. LOCATION (City or Town) (County) (State) <i>Syracuse T.Y.</i>			
24. FUNERAL DIRECTOR <i>Arthur Walters</i> <i>Takoma Park</i> <i>254 Carroll St NW</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
					DATE <i>JAN 31 1968</i>				

01132

STATE OF TEXAS

01132

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01125		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01123	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) ^{First} <u>Esther</u> ^{Middle} <u>May</u> ^{Last} <u>Dick</u>				2a. DATE OF DEATH ^{Month} <u>01</u> ^{Day} <u>22</u> ^{Year} <u>68</u>		2b. HOUR <u>6:05</u> ^A <u>M</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>5-10-02</u>		6. AGE (In years last birthday) <u>65</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Pa.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium & Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Ret. Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Takoma Park</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ^{First} <u>Charles</u> ^{Middle} <u>Zimmer</u> ^{Last}		15. MOTHER'S MAIDEN NAME ^{First} <u>Wilhelmina</u> ^{Middle} <u>Hoffman</u> ^{Last}		13e. STREET AND NUMBER <u>8115 Carroll Ave.</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>213 38 4885</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage, intra cerebellar</u> <u>431.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>330x Coronary artery disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY ^{HOUR A.M.} <u></u> ^{Month} <u></u> ^{Day} <u></u> ^{Year} <u>19</u> ^{P.M.} <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED ^{While} <input type="checkbox"/> ^{Not while} <input type="checkbox"/> ^{at work} <input type="checkbox"/> ^{at work} <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION ^{Street or R.F.D. No.} <u></u> ^{City or Town} <u></u> ^{County} <u></u> ^{State} <u></u>			
22a. I certify that (I) (this hospital), attended the deceased from <u>JAN 21, 1968</u> , to <u>JAN 22, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Jan 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John L. Ford</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>Jan 22 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD MD</u>				22e. ADDRESS <u>831 UNIVERSITY BLVD E SILVER SPRING MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Jan. 24-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City or Town) <u>Bladensburg Rd. & Lee Rd</u> (County) <u></u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>Arthur Kellers</u>		ADDRESS <u>254 Carroll Ave</u>		25. REC'D BY REGISTRAR <u>RE</u> DATE <u>JAN 25 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James Jones</u>	

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
01126 CERTIFICATE OF DEATH 01124									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR AM PM
Russell			Conwell	Diehl		January 17 1968			5:20 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		28 July 1950		17 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center			Student		--	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Frostburg			70 Walnut Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Robert			Diehl			Catherine			Parker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address				
No			None		The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative sepsis and shock</u> <u>2051</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute blastic crisis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic myelogenous leukemia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>2041</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (A) (this hospital) attended the deceased from <u>October 30, 1967</u> , to <u>January 17, 1968</u> , that (A) (we) last saw the deceased alive on <u>January 17, 1968</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death.									
22b. SIGNATURE <u>George P. Canellos</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>17 Jan 68</u> <u>1-17-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>George P. Canellos, M.D.</u>						22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>JAN. 20, 1968</u>		<u>FROSTBURG MEM. PARK</u>		<u>FROSTBURG</u>		<u>MARYLAND</u>	
24. FUNERAL DIRECTOR <u>FRANK M. SOWERS</u> <u>MANLYN M. SOWERS</u>						25a. REC'D BY REGISTRAR <u>JAN 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>FRANCIS B. DILLON</i>			2a. DATE OF DEATH Month Day Year <i>1 15 68</i>			2b. HOUR <i>10:30 AM</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>12/2/96</i>		6. AGE (In years last birthday) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3525 Glenallen Ave.</i>	
14. FATHER'S NAME First Middle Last <i>MATTHEW A. DILLON</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>EDITH BENNETT</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>YES</i>			16b. SOCIAL SECURITY NO. <i>578-09-1967A</i>		17. INFORMANT <i>MATTHEW DILLON</i>		Address <i>4213 QUEEN MARY DR. BLNEY MD</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastric hemorrhage; stress ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis, rt. internal carotid artery</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>10 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>332 X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 5, 1968</i> , to <i>Jan. 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 15</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Raymond Bradshaw, MD</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Jan. 15, 1968</i>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Jan 18-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring Md. Montgomery Md.</i>			
24. FUNERAL DIRECTOR <i>TAKOMA FUNERAL HOME</i>					25. REC'D BY REGISTRAR <i>2546</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
					DATE <i>JAN 19 1968</i>				

UNITED STATES DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

JULY 1910

BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

JULY 1910

BUREAU OF PLANT INDUSTRY

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JULY 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01126

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>19 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		d. STREET ADDRESS <u>11500 Newfort Mill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11500 Newfort Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR JOSEPH DINGER</u>		4. DATE OF DEATH <u>JANUARY 10, 1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>1968</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonathan Dinger</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Hildebrecht</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-9226</u>	
17. INFORMANT <u>Maebel H. Dinger</u>		Address <u>Same as #2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF STOMACH</u> DUE TO (b) <u>STOMACH</u> DUE TO (c) <u>STOMACH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>151X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1941</u> , to <u>10 JAN 1968</u> , that (I) (we) last saw the deceased alive on <u>24 DEC 1967</u> , and that death occurred on <u>8 20</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>A. H. Richwine</u>		22b. DATE SIGNED <u>1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>ATT. RICHWINE, M.D.</u>		22d. ADDRESS <u>5522 WESTERN AVE. CHEVY CHASE, 15, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/1/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Calmar Manor Md.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20012</u>		DATE <u>JAN 15 1968</u>	

01132

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

01130

UNITED STATES DEPARTMENT OF THE INTERIOR

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "BUREAU OF LAND MANAGEMENT" and "UNITED STATES DEPARTMENT OF THE INTERIOR" are visible.]

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Julia Victoria Doggett						2a. DATE OF DEATH Month Day Year Jan 22 1968			2b. HOUR 1:10PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-10-15			6. AGE (In years last birthday) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Va		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash San & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hs.			12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Prince Georges			13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7908 Wildwood Dr.		
14. FATHER'S NAME First Middle Last Robert Staples			15. MOTHER'S MAIDEN NAME First Middle Last Sophia ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.			16b. SOCIAL SECURITY NO. 578105249			17. INFORMANT Address Med records Wash San & Hosp.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 593.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 603x (b) Renal Shut Down DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture of right Femur and Adrenal insufficiency												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR 10:00M. Month Day Year 11-27-1967		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) patient fell at home								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) home		21f. LOCATION Street or R.F.D. No. City or Town County State 7908 Wildwood Drive, Takoma Park, Md.								
22a. I certify that (I) (this hospital) attended the deceased from 3-25- , 19 63 , to 1-22- , 19 68 , that (I) (we) last saw the deceased alive on 1-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Russell B. Arnold						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-22-68				
22d. PHYSICIAN'S NAME (Type) Russell B. Arnold, M. D.						22e. ADDRESS 1106 Spring Street, Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/26/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland Maryland					
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.						25a. REC'D BY REGISTRAR 2434 Georgia Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01130

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01128

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1103 Caddington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie (no middle name) Dolin		4. DATE OF DEATH Month 1 Day 20 Year 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1886
9. AGE (In years lost birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millinery clerk	11. BIRTHPLACE (County & State, or foreign country) Rumania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Raphael Simon	
14. MOTHER'S MAIDEN NAME Caroline ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 076-20-7533		17. INFORMANT Dr. Eveline D. Schulman, same as 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2041 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO (b) CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO (c) NOTE: RHEUMATOID - GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 4 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NOTE: RHEUMATOID - GENERALIZED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2 PM to 1-20 , 19 68 , that (I) (we) lost saw the deceased alive on 1-20 19 68 , and that death occurred on 1-20 M, from causes and on the date stated above.			
22a. SIGNATURE Harold Sterling, M.D.		22b. DATE SIGNED 1/20/68	
22c. PHYSICIAN'S NAME (Type) Harold Sterling, M.D.		22d. ADDRESS 1352 University Blvd. E. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 22, 1968	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.	23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR JAN 23 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

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University of California, Berkeley

Department of Chemistry

Chemistry Department

University of California, Berkeley

Department of Chemistry

Chemistry Department

University of California, Berkeley

Department of Chemistry

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Department of Chemistry

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University of California, Berkeley

Department of Chemistry

Chemistry Department

01131

CERTIFICATE OF DEATH

01129

1. DECEASED-NAME (Type or print) Robert Short DOWDLE			2a. DATE OF DEATH Month January Day 7 Year 68			2b. HOUR 930 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 6, 1936		6. AGE (in years last birthday) 31 YRS.	
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Navy Reserve		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Texas		13b. COUNTY Nacogdoches		13c. CITY OR TOWN Nacogdoches		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Route 3, Box 163		14. FATHER'S NAME First Middle Last William Chester Dowdle		15. MOTHER'S MAIDEN NAME First Middle Last Reba Zelma Short			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 1954-1968 430 58 8744		17. INFORMANT Nacogdoches, Texas		Address Mrs. Catherine K. Dowdle, Route 3, Box 163	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terato Carcinoma Mediastinum 1631 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 164X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1967 , to Jan. 7, 1968 , that (I) (we) last saw the deceased alive on Jan. 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Elliot Perlin MD</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 9, 1968	
22d. PHYSICIAN'S NAME (Type) Elliot Perlin, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 1-10-68		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Odessa, Texas	
24. FUNERAL DIRECTOR Falls Church				ADDRESS Funeral Home, 1102 West Broad St., Falls Church, Va.		25a. REC'D BY REGISTRAR JAN 11 1968	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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01132

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01130

1. DECEASED-NAME (Type or print) Ethel Marguerite Eilers			2a. DATE OF DEATH Month Day Year January 14 1968			2b. HOUR 1:30 M.							
3. SEX Female		4. RACE White		5. DATE OF BIRTH 20 May 1950		6. AGE (In years last birthday) 17 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY ---			13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 215 Dart Drive			
14. FATHER'S NAME First Middle Last Henry W. Eilers, Jr.			15. MOTHER'S MAIDEN NAME First Middle Last Eva Shephard										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Records, Address The Clinical Center, Bethesda, Maryland 20014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram-negative septicemia 2050 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) Acute myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2043								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
								4 days					
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 11 December 1967, to 14 January 1968, that (X) (we) last saw the deceased alive on 14 January 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert A. Ralph MD DEGREE								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 14 January 1968			
22d. PHYSICIAN'S NAME (Type) Robert A. Ralph, MD								22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 1/17/68		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery			23d. LOCATION (City or Town) (County) (State) Fairfax Co. Va.					
24. FUNERAL DIRECTOR Alex Wheatley Funeral Home Alexandria, Va.								25a. REC'D BY REGISTRAR DATE JAN 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>2/19 To 4/1/68</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>5730 Conn. Ave. N.W. #309</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>H.</u> Last <u>EMMERSON</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1968</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29-1884</u>		9. AGE (In years last birthday) <u>83</u> yrs.	10. UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (County & State, or foreign country) <u>- Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MORRIS Emerson</u>				14. MOTHER'S MAIDEN NAME <u>Ida - HARRIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI WWII</u>		16. SOCIAL SECURITY NO. <u>577-50-9903</u>		17. INFORMANT <u>Kathryn I. Emerson (Wife)</u> Address <u>#2 above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>412.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>430.0</u> } (b) <u>Pulmonary edema</u> (c) <u>A.S.H.T.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>several yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/22, 1967</u> to <u>April 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1968</u> , and that death occurred at <u>7:00 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Wadler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 Wisc. Ave. Bth. Yd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 5 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Minerals Judge</u>	

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OFFICE OF DEAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01134			01132						
1. DECEASED-NAME (Type or print) MAURINE E. EMRICK			2a. DATE OF DEATH Month Jan Day 28 Year 1968			2b. HOUR 12:40 A.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH Oct 4 1895		6. AGE (In years last birthday) 72		7. AGE (In years last birthday) 72	
7a. BIRTHPLACE (State or foreign country) UTAH		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WHEATON NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Economist		12b. KIND OF BUSINESS OR INDUSTRY Comm. U.S.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12921 Cristfield Road	
14. FATHER'S NAME HENRY N. KOTTER		15. MOTHER'S MAIDEN NAME Preda LARSEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-46-0862		17. INFORMANT Joe M. Bulla	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis, Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years 12 years		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Mar 27 , 19 62 , to Jan 27 , 19 68 , that (I) (we) last saw the deceased alive on Jan 27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Berkenbilt MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Jan 28, 1968			
22d. PHYSICIAN'S NAME (Type) JOSEPH BERKENBILT		22e. ADDRESS 2121 Pennsylvania Ave NW							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.			
24. FUNERAL DIRECTOR John B. Warner		24a. ADDRESS John B. Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR JAN 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

01134

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RECEIVED

1960-11-17

CLEARED WITH MEDICAL EXAMINER,
DR. BELDEN REAP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

01135		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01133			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Margot			T.		Evans	January 31, 1968		11:28 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
female		cau		2/9/07		60 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Illinois		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		Medical Technician					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Rockville		YES		1113 Lewis Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Edward					Thompson	Elsea			Sprinks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no						Ann Evans, daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Prosthetic (Starr-Edwards) Valve</u> <u>3950</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease (Postoperative)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>411X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>① Carcinoma of Colon ② Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from <u>1964</u> to <u>Jan 31, 1968</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Herman C. Magazini</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/1/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Herman C. MAGAZINI</u>					22e. ADDRESS <u>50W. Edmonston Dr. Rockville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		2-2-68		Cedar Hill Crematory		Suitland, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland					FEB 6 1968		<u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
011334									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR PM
Pearl Ellen Evans						January 17 1968			5:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		26 May 1908		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
South Carolina		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
South Carolina		V		Lancaster				407 Gillsbrook Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James Blackmon						Charlotte Caston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
			249-03-4218		The Medical Records, The Clinical Center/				Bethesda, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>2021</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2021</u> (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mycosis Fungoides</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>4 weeks</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Osteoporosis and Hypercalcemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>8 November, 1967</u> , to <u>17 January 1968</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>17 January 1968</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) did <u>(did not)</u> view the body after death.									
22b. SIGNATURE <u>Joseph D. Croft, Jr.</u>						22c. DATE SIGNED <u>18 January 1968</u>			
22d. PHYSICIAN'S NAME (Type) Joseph D. Croft, Jr.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-20-68		Lancaster Mem. Park		Lancaster, So. Carlina			
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE JAN 24 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01137

CERTIFICATE OF DEATH

01135

1. DECEASED-NAME (Type or print) Robert RANDALL Evans			2a. DATE OF DEATH Month Jan Day 24 Year 1968		2b. HOUR 6:30a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8/6/08		6. AGE (In years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md.			10. CITY OR TOWN OF DEATH Silver Spring		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Budget Director U.S.A.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME First Robert Middle Cleveland Last Evans		15. MOTHER'S MAIDEN NAME First Emma Middle Bush Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 217-42-8617		17. INFORMANT Gene Mari Evans Address 220 Whitmoor Terrace Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492x (b) DUE TO, OR AS A CONSEQUENCE OF (c) 5271					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic heart disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1968 to 1-24, 1968 , that (I) (we) lost saw the deceased alive on 1-23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George William Ware DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) George William Ware				22e. ADDRESS 1835 9. Street, N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE January 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION (City or Town) Silver Spring (County) Mont. (State) Md.		24. FUNERAL DIRECTOR Warner E. Humphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.			
25a. REC'D BY REGISTRAR DATE JAN 26 1968				25b. REGISTRAR'S SIGNATURE Charles Judge	

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Cleared by Coroner Dr. Belden Reap 68

MEDICAL CERTIFICATION

A34
4/19/68
VR 15-14
30M REV. 11-68

01137

DEPARTMENT OF THE INTERIOR

01137

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
JOHN			R. FANNING			Jan. 26, 1968		4:30 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		1/13/15		53 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Penna.		U.S.A.				MONTGOMERY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross Hosp 1500 Forest Glen Rd		Officer - Old Dom. Steel Corp						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Mont.		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5005 Cushing Dr.		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
Francis Fanning						Stella Russell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
No			009-03-7292			Winnifred Fanning			Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u>								2 hr.		
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Acute coronary artery thrombosis &</u>								10 hr.		
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>myocardial infarction</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<u>Sclerohyaline arteriosclerosis cardio-vasc. disease.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>26 Jan</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>26 Jan</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
<u>Ernest E. Harmon M.D.</u>								22c. DATE SIGNED		
								<u>26 Jan 68</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
<u>Ernest E. Harmon M.D.</u>				<u>9301 Colesville Rd Silver Spring Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>1-29-68</u>		<u>Gate of Heaven Cem.</u>		<u>Silver Spring, Md.</u>				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
<u>ROBERT A. PUMPHREY, Bethesda, Md.</u>				DATE <u>FEB 2 1968</u>				<u>Charles Judge</u>		

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1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
VIRGINIA H. FEELEY						Jan. Month 7 Day 68 Year			11:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F		W		7-16-1901		66 years			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ALABAMA		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING			HOLY CROSS			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD.			MONT.		KENSINGTON		YES		10225 KENSINGTON PKWY
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Claude Hardy			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			214-32-9491		Mrs. Thomas Brewer 1603 Brisbane Street Silver Spring, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas with</u> <u>157.9</u> DUE TO, OR AS A CONSEQUENCE OF <u>extensive metastases.</u>									4 MON.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
157X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/30, 1967</u> , to <u>1/7, 1968</u> , that (I) (we) lost saw the deceased alive on <u>1/7, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Harold S. Tidler M.D.								1/8/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
HAROLD S. TIDLER M.D.				22 8402 FENTON ST., S.S., MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 11, 1968		Arlington, Nat'l. Cemetery		Arlington, Va.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John B. Thompson & Son, Inc.				8434 Georgia Ave. Silver Spring, Md.		DATE JAN 11 1968		Charles Judge	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) ESTHER		First Middle Last		2a. DATE OF DEATH JAN. Month 30 Day 1968 Year		2b. HOUR 8:10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug 15, 1893		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9006 Linton Street		14. FATHER'S NAME First Middle Last Selig Morris		15. MOTHER'S MAIDEN NAME First Middle Last Lena			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Arthur Fefferman		Address same as 13 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction massive 4330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral & generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X Diabetes mellitus; hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March, 1966 , to 1-29, 1968 , that (I) (we) last saw the deceased alive on 1-25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jason Geiger, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-30-68	
22d. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		22e. ADDRESS 800 Pershing Drive, Sil Spg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-31-68		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery		23d. LOCATION (City or Town) (County) (State) Woodbridge, N.J.	
24. FUNERAL DIRECTOR Goldberg Funeral Home				ADDRESS 4217 9th Street N.W.		25a. REC'D BY REGISTRAR DATE JAN 31 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. *Chlorophyll a* and *Chlorophyll b* content of the leaves of *C. sinensis* and *C. sinensis* var. *sinensis* were determined by the method of Arar and Johnson (1996).

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Journal of Applied Social Psychology

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|-------|---|--|--------------------------------|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 01141 | | | | | 01139 | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MAGGIE | | | | B. | | FELLOWS | | Month Day Year
Jan. 5, 1968 | | P. 12:30 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| Female | | Caucasian | | April 19, 1883 | | 84 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Penna. | | U.S.A. | | | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| Silver Spring | | Fairland N.H. | | Housewife | | At Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Montg. | | Chevy Chase | | | | 4709 Dorset Avenue | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Jacob Eisenhart | | | | | | | | Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | | | | Mary B. Hughes, Dtr., Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>UREMIA</u>
<u>4409</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>GENERALIZED ARTERIAL Sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4500</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (did not) attended the deceased from <u>10/27/</u> 19 <u>66</u> , to <u>1/5/</u> 19 <u>68</u> , that (I) (did not) saw the deceased alive on <u>1/4/</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death. | | 22b. SIGNATURE
<u>Richard Delaney MD</u>
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/5/68</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>R. P. Delaney</u> | | 22e. ADDRESS
<u>4323 Harvard St., Silver Spring, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<u>1/ / 68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Middletown Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Middletown, Pa.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>JAN 10 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | | | | | |

01110

01110



0001-11110

FOR STATE
HEALTH DEPT.

18
film 398 3-22a
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01140

| | | | | | | | |
|--|----------------------|--|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) <u>TAlmage</u> First <u>Matthew</u> Middle <u>Fink</u> Last | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>JAN</u> Day <u>28</u> Year <u>1968</u> | | | 2b. HOUR <u>4:45</u> M | |
| 3. SEX <u>male</u> | 4. RACE <u>white</u> | 5. DATE OF BIRTH <u>1/28/96</u> | 6. AGE (In years last birthday) <u>72</u> YRS | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | IF UNDER 24 HRS. HOURS _____ MIN. _____ | 2c. DATE PRONOUNCED DEAD Month <u>JAN</u> Day <u>28</u> Year <u>1968</u> | |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>MONTGOMERY</u> Md. | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired Carpenter - Gov't</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Boyd's</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <u>Box 276</u> |
| 14. FATHER'S NAME First <u>Frank</u> Middle <u>Fink</u> Last <u>Fink</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Milissa</u> Last <u>Schow</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16b. SOCIAL SECURITY NO. <u>577-14-3057</u> | | 17. INFORMANT <u>Alpha R. Fink</u> ADDRESS <u>48 West Deer Park Dr.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>887X Penetrating Fat embolization of Brain, liver</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>and kidneys</u> | | | | | | | 6 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture of Hip</u> | | | | | | | 23 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9040</u> | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year <u>7 P.M. Jan 5 1968</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell at home -</u> | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home -</u> | | 21f. LOCATION Street or R.F.D. No. <u>R.F.D. - Box 276</u> | | City or Town <u>Boyd's</u> County <u>Montgomery</u> State <u>Md.</u> | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>John G Ba 11</u> | | | 22b. DATE SIGNED <u>28 Jan 1968</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>1-31-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Germantown Baptist</u> | | 23d. LOCATION (City or Town) <u>Germantown Mont</u> (County) <u>Md</u> (State) |
| 24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 2 1968</u> | | 25b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

52170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
THELMA Fox | | | 2a. DATE OF DEATH
Month Day Year
Jan 11 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
Dec. 27, 1897 | | 6. AGE (In years last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Newark New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bairland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bairland Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
representative | | 12b. KIND OF BUSINESS OR INDUSTRY
AVON COSMETICS | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Prince George's | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
314 Laurel Avenue | | | |
| 14. FATHER'S NAME
First Middle Last
David F. Handley | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie Walkman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
213-38-1073 | | 17. INFORMANT
Address
Mahel Halman Laurel Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
4369
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331X</u>
(b) <u>Cerebrovascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Essential arteriosclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
2 months
10 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes Mellitus, Cholelithiasis & Anemia.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1938, to 1/11, 1968, that (I) (we) last saw the deceased alive on 1/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. M. Warren | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type)
J. M. WARREN | | 22e. ADDRESS
Laurel Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-15-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cem | | 23d. LOCATION (City or Town) (County) (State)
Arlington Va | | | |
| 24. FUNERAL DIRECTOR
Address
De Witt Samsel, Laurel Md | | 25a. REC'D BY REGISTRAR
DATE
JAN 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Phyllis Judge | | | | | |

0110

01144

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01142

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|------------------|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print) Mary Noreen Franck. | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 18 Year 1968 | | | 2b. HOUR 9:23 AM |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH Jan 23 1896 | 6. AGE (in years last birthday) 71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Jan. Day 18 Year 1968 |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va. | | 13b. COUNTY Richmond | | 13c. CITY OR TOWN Richmond | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4727 Patterson Ave. |
| 14. FATHER'S NAME First John Middle T Last Hardy | | | 15. MOTHER'S MAIDEN NAME First Kate Middle Walton Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. 220-44-9361 | | 17. INFORMANT ADDRESS Son Carlisle W. 410 Oak St. Gaithersburg Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Coronary Insufficiency Acute
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden

Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | EXAMINER'S NAME (Type) John G. Ball | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Jan 18 1968 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Lawn | | 23d. LOCATION (City or Town) (County) (State) Richmond, Va. |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | 25. REC'D BY REGISTRAR JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01145

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01143

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|----------------------|--------------------------------|-------|--|
| 1. DECEASED NAME
(Type or print) | | | First
Ambrose | Middle
(None) | Lost
Frazier | 2a. DATE OF DEATH
Month Day Year
January 23, 1968 | | | 2b. HOUR P
4:21 M | | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
18 February 1906 | | 6. AGE (In years
lost birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Foreman | | 12b. KIND OF BUSINESS OR
INDUSTRY
UNKNOWN | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
District of Columbia | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4407 Grant Street, N.E. | | | | |
| 14. FATHER'S NAME
First Middle Lost
James C. Frazier | | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
Gertrude Cooper | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
579-07-8878 | | 17. INFORMANT
The Medical Records, Address
The Clinical Center, Bethesda, Maryland 20014 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Retroperitoneal hemorrhage
204.1 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Chronic Lymphocytic Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 - 5 days
31 months | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
2040 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 23, 1968, to January 23, 1968, that (I) (we) last saw the deceased alive on January 23, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
John W. Keyes, Jr. MD | | | | | MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
24 February 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John W. Keyes, Jr. MD | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
1/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | | | | | Washington, D.C. | | | | | | |
| 24. FUNERAL DIRECTOR
Stewart Funeral Home-4001 Benning Road, | | | | | 25a. REC'D BY REGISTRAR
JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Wheaton, Md.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Langley Park, 8113 15th Ave.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>University Nursing Home</i> | | d. STREET ADDRESS
<i>901 AREOLA Avenue</i> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<i>SARAH FREED</i> | | 4. DATE OF DEATH
Month Day Year
<i>1 26 1968</i> | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>unknown</i> |
| 9. AGE (years lost birthday)
<i>87</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Poland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Chaim Servetta</i> | | 14. MOTHER'S MAIDEN NAME
<i>Yuta L.</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>none</i> | |
| 17. INFORMANT
<i>Nursing Home Records</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>terminal Bronchopneumonia</i>
DUE TO (b) <i>Viral Influenza</i>
DUE TO (c) <i>lost. 470X</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs.</i>
<i>36 hrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>Senility, arteriosclerotic Heart Disease</i> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 6, 1966</i> , to <i>JAN. 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>1/20 1968</i> , and that death occurred at <i>10:30 PM</i> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>MAX G. SHERER</i> | | 22b. DATE SIGNED
<i>1/26/68</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>MAX G. SHERER</i> | | 22d. ADDRESS
<i>800 Residing Drive Silver Spring</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>Jan. 29/68</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Zion Cem.</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Long Island, N.Y.</i> |
| 24. FUNERAL DIRECTOR
<i>B. Langworthy & Sons</i> | | 25a. REC'D BY REGISTRAR
<i>3501-14th St.</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
<i>JAN 30 1968</i> | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|--|-------------------|---|--|-----------------------------------|--|
| 01147 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Frank Sands French | | | | | | Month Day Year | | | 120 A.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| MALE | | WHITE - Amer. | | 11-27-1899 | | | 68 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | | WASHINGTON SAM'S HOSPITAL | | | RET. CONTRACTOR | | Petroleum Ser. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | Montgomery | | Silver Spring | | YES | | 209 Hartwell Rd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| William Henry French | | | Emily Ott | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| (Yes, no, or unknown) | | | 22-054493 | | AMELIA FRENCH | | 13-C-13-LAVER. | | |
| | | | WNI Ordinance Dept. | | Hospital Record. | | 1600 Carroll | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | 8 years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Chronic Bronchitis with Emphysema | | | | | | | | | 12 years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Influenza | | | | | | | | | 14 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Papillary Carcinoma of urinary bladder, arrested | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| DEC 26 1967 | | Tracheostomy | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. Month Day Year | | | | | | | |
| (If either, notify medical examiner) | | P.M. | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | City or Town County State | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | Street or R.F.D. No. | | | | | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1953, to Jan 2, 1968, that (I) (we) lost saw the deceased alive on Jan 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| George L Ball | | | | | | | | Jan 7, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. ADDRESS | | | | | |
| George L Ball | | 10620 Georgia Ave | | Silver Spring Md 20902 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1968 | | Cedar Hill Cemetery | | Suitland, Maryland | | | |
| 24a. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| C. Glen Carter | | 8434 Georgia Ave. | | JAN 10 1968 | | Charles Judge | | | |
| Warner E. Humphrey, Inc. | | Silver Spring, Md. | | | | | | | |

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UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---------------|--|---------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01148 | | | | | | | | | |
| 01146 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Annie Jeannette Fulford | | | | | | 1/5/1968 | | 5:00P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | Negro | | 2/16/1878 | | 89 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| No. Carolina | | USA | | | | Montgomery County | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Wheaton | | University Nursing Home | | Domestic worker | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Washington, DC | | ✓ | | Wash., DC | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18 Que St., NE | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| Charles (?) Nelson | | | Madora ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| no | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>STROKE</u>
4369 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
334X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21/1962, to 1/5/1968, that (I) (we) last saw the deceased alive on 1/5/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| Walter Goozh | | JAN 5 1968 | | Walter Goozh, M. D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | | |
| 2309 Shorefield Rd., Wheaton, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan 9, 1968 | | Lincoln Memorial Cemetery | | 4001 Suitland Rd, Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| 309 6th St N.W. | | DATE JAN 10 1968 | | Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|-----------------------------------|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|
| 01149 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01147 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
WALTER S FURLOW | | | | | | | | | | | | 2a. DATE OF DEATH
January Month 23 Day 1 Year 68 | | | | | | | | | | | | 2b. HOUR
6:15 PM | | | | | | | | | | | |
| 3. SEX
MALE | | | | 4. RACE
Cauc. | | | | 5. DATE OF BIRTH
Dec. 10, 1888 | | | | 6. AGE (in years
last birthday)
79 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Minn. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Carroll Hall | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Adv. Mgr. Newspaper | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | | 13b. COUNTY
Montgomery | | | | 13c. CITY OR TOWN
Chevy Chase | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
5819 Highland Drive | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Samuel C. Furlow | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Jones | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
Yes | | | | (If yes give war or dates of service)
WW I | | | | 16b. SOCIAL SECURITY NO
578-10-2082 | | | | 17. INFORMANT
Wife | | | | Address
Same as Item 13. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 402X HYPERTENSIVE HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(b) ESSENTIAL HYPERTENSION
DUE TO, OR AS A CONSEQUENCE OF
(c) GENERALIZED ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
443X SENSITIVITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 14, 1968, to JAN. 23, 1968, that (I) (we) last
saw the deceased alive on JAN. 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Henry M. Lowden MD | | | | | | | | | | | | DEGREE
ATTENDING
PHYS. | | | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. | | | | 22c. DATE SIGNED
JAN. 23, 1968 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) HENRY M. LOWDEN | | | | | | | | | | | | 22e. ADDRESS
5306 Norway Dr.
Cherry Hill, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE
1-25-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 2 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MONTGOMERY STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 01150 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01148 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | | | c. LENGTH OF STAY IN 1b
<u>10 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Springs</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home</u> | | | | | | d. STREET ADDRESS
<u>9408 Wire Ave</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Lillian Cecilia Gallagher</u> | | | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>6</u> Year <u>1968</u> | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>4/16/1884</u> | | 9. AGE (In years last birthday)
<u>83</u> yrs. | | IF UNDER 1 YEAR
Months <u>6</u> Days <u>19</u> Hours <u>6</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Nova Scotia, Canada</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Hugh MacInnis</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Barrett</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO.
<u>577-16-0035</u> | | 17. INFORMANT
Address <u>Mrs. John Bowles, 9408 Wire Ave. S.S. MD.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage.</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Platelet deficiency</u>
DUE TO
(c) <u></u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 1/2 hours</u>
<u>2 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>578x</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August, 1957</u> , to <u>Jan. 6, 1958</u> , that (I) <u>was</u> last saw the deceased alive on <u>Jan 2</u> 1968, and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Samuel T. Kimball</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>6 Jan. '68</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u></u> | | | | | | 22d. ADDRESS
<u>9801 Georgia Ave Silver Spring Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>1/9/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet D.C.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D. C.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Francis J. Collins-3821-1451 N.W.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 10 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01151 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01149 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|---|--|------------------------|--|--|------------------|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| George H. Ganson | | | | | | | | | | Month 1 Day 17 Year 68 | | | | | | | | | | 10 P M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| male | | | white | | | 12/13/11 | | | 56 YRS. | | | MONTHS DAYS | | | HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Ohio | | | U.S. | | | | | | Montgomery County Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Silver Spring | | | Holy Cross | | | Hotel Owner | | | Hotel | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Florida | | | | | | Delray | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 722 Northeast 2nd St. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| George Henry Ganson sr | | | Minnie Miller | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| Yes, no, or (unknown) | | | 272-09-3268 | | | Amelia L. Ganson | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Anoxia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 412.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 2 mo | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease & | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Disease | | | | | | | | | | 2 yr | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | City or Town County State | | | | | | | | | | | | | | | | | | | | |
| | | | | | | Street or R.F.D. No. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/24, 1967, to 1/17, 1968, that (I) (we) lost the deceased alive on 1/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dr. J. C. Cullen MD | | | 1/17/68 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| Cremation | | | 1/18/68 | | | Lee's Crematorium | | | Washington, D. C. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |
| Lee Funeral Home | | | DATE | | | JAN 22 1968 | | | Charles Judge | | | | | | | | | | | | | | | | | | | | |
| Washington, D. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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CERTIFICATE OF DEATH

01150

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(Type or print) | | First
William | | Middle
Harold | | Last
Geatches | | 2a. DATE OF DEATH
Month
January 5, 1968
Day
Year | | 2b. HOUR
6:15 P.M.
605P | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
5 June 1928 | | 6. AGE (In years
last birthday)
39 | | 7. UNDER 1 YEAR
MONTHS
DAYS | | 8. UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Professor | | 12b. KIND OF BUSINESS OR
INDUSTRY
University | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Route 5, Box 26-BB | | | |
| 14. FATHER'S NAME First
George Geatches | | | | 15. MOTHER'S MAIDEN NAME First
Muriel | | | | Middle
Burris
Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | 16b. SOCIAL SECURITY NO.
1946-60 | | 17. INFORMANT
The Medical Records
The Clinical Center, Bethesda, Maryland 20014 | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Localized empyema intra abdominal
2050 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Acute myelogenous Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
days
25 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
2043 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 11 October, 1967, to 5 January, 1968, that (X) (we) last
saw the deceased alive on 5 January 1968, and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert C. Young MD DEGREE
22d. PHYSICIAN'S
NAME (Type)
Robert C. Young, M.D. | | | | | | | | 22c. DATE SIGNED
6 January 1968 | | 22e. ADDRESS
The Clinical Center, National
Institutes of Health, Bethesda, Md. 20014 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
1-9-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BAHOTO NATIONAL | | 23d. LOCATION (City or Town)
BALTIMORE | | (County)
Md. | | (State) | |
| 24. FUNERAL DIRECTOR
John M. Young & Sons Annapolis, Md. | | | | 25a. REC'D BY REGISTRAR
DATE
JAN 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01130

01130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01153 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01151 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CARROLL LEE GEORGE | | | | | | | | | | JAN 7 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MALE | | | | | | | | | | CAUCASIAN | | | | | | | | | | MARCH 30, 1908 | | | | | | | | | | 57 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WASHINGTON, D.C. | | | | | | | | | | U.S. | | | | | | | | | | | | | | | | | | | | MONTGOMERY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | | | | | | | | | 10607 KENILWORTH AV. | | | | | | | | | | MAINTENANCE MAN | | | | | | | | | | U.S. NAVAL PLANT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | | | | | | | MONTGOMERY | | | | | | | | | | BETHESDA | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 10607 KENILWORTH AV. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CARROLL LEE GEORGE | | | | | | | | | | HATTIE A. DAMMEYER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES | | | | | | | | | | KOREAN | | | | | | | | | | NONE. | | | | | | | | | | MRS. LILLIAN M. GEORGE | | | | | | | | | | SAME AS #13. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CORONARY ARTERIO SCLEROSIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1964, to Jan 7, 1968, that (I) (we) last saw the deceased alive on Dec 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Don B. Cameron | | | | | | | | | | JAN 8, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DON B. CAMERON | | | | | | | | | | 3503 PERRY ST. MT. RAINIER, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | JAN 10, 1968 | | | | | | | | | | FORT LINCOLN | | | | | | | | | | COLMAR MARION, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| W.W. CHAMBERS CO. RIVERDALE, MARYLAND | | | | | | | | | | DATE | | | | | | | | | | JAN 15 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

CERTIFICATE OF DEATH

01154

01152

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) MARK | | First Middle Last
GERMAN | | 2a. DATE OF DEATH
Jan. Month 11 Day Year 68 | | 2b. HOUR
10:55 | |
| 3. SEX
Male | | 4. RACE
Cau. | | 5. DATE OF BIRTH
1/11/68 | | 6. AGE (In years
last birthday)
YRS. MONTHS DAYS
7 45 | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) HolyCross | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
never worked | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1013 Robin Rd | | 14. FATHER'S NAME First Middle Last
Bruce German | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margarite | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Bruce German (father) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
7599 IMMEDIATE CAUSE (a) Multiple Congenital Anomalies
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 7593 (b) Sub Archnoid Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Prematurity | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 11 , 19 68 , to Jan 11 , 19 68 , that (I) (we) lost
saw the deceased alive on Jan 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Arthur S. Bresler</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) Arthur S. Bresler | | | | 22e. ADDRESS
10881 Lockwood Dr., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
1/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. | |
| 24. FUNERAL DIRECTOR
Lyson Wheeler Funeral Home-1331 Rockville Pike
Rockville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11/11/63

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 398 MARYLAND STATE DEPARTMENT OF HEALTH
3-12-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01153

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|---|--|--|---|--|--|------------------------------|--------------------------------|--|---|--|--|------------------------------|-----|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last
WILSON RAY GERMAN | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year
1 20 1968 | | | 2b. HOUR
1:15 P.M. | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2-6-45 1918 | | 6. AGE (In years last birthday)
19-58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
1 20 1968 | | | 2d. HOUR
1:15 P.M. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Md | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery | | | | Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | | | 13b. COUNTY
Montgomery | | | | | | 13c. CITY OR TOWN
Gaithersburg | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET AND NUMBER
21 Mills Road | | | | | |
| 14. FATHER'S NAME
First Middle Last
William S. German | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Elsie Phoebe | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | | | 17. INFORMANT
Juanita Bohrer, sister, Gaithersburg, Md | | | | | | ADDRESS | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Laceration of abdomen with
956x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) internal hemorrhage, self-inflicted
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
977x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
9:00 A.M. 1-20 1968 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Deceased stabbed self with large knife. | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Gaithersburg Montgomery Md | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED
JAN. 20, 1968 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS Street, city, town, or county
Gaithersburg, Md | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | 23b. DATE
1-23-68 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | | | | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg, Montg. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Ernest C. Gartner, Gaithersburg, Md | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
JAN 29 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|---------|------------------------------|--|--|---|---|--|-----------------------------------|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| CECIL HARRIS GIBSON | | | | | | MAY 26 1968 | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | |
| M | W | 9-28-27 | 48 YRS | MONTHS DAYS | | HOURS MIN | | MAY 1-26 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| VIRGINIA | | USA | | | | MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TAKOMA PARK | | | WASH. SAN & HOSPITAL | | | DRIVING INSTRUCTOR | | Easy Method Co | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | PRINCE GEORGES | | HYATTSVILLE | | YES | | 8310 14TH AVE. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| OPHERY H GIBSON Sr. | | | LORENE LOREEN EUBANK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| YES | | | WWII | | 227-22-9936 | | WIFE (JEAN) SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Artery Heart Disease | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | JAN. 26, 1968 | | | | |
| Belden R. Reap, M.D. | | | ADDRESS (Street, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 11/29/68 | | George Washington Cem. | | Hyattsville P.G. Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| C. Glen Carter | | | | DATE JAN 30 1968 | | Charles Judge | | | | |
| Warner E. Humphrey Inc. | | | | 8434 Ga. Ave. S.S. Md | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01157

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01155

| | | | | | | | | |
|---|----------------------|--|--|--|--|---|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Geoffrey Marshall Gibson</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Jan</i> Day <i>9</i> Year <i>1968</i> | | | 2b. HOUR <i>5:30</i> | | |
| 3. SEX <i>male</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>1/3/18/51</i> | 6. AGE (In years last birthday) <i>16</i> YRS. | IF UNDER 1 YEAR
MONTHS <i>0</i> DAYS <i>0</i> | IF UNDER 24 HRS.
HOURS <i>0</i> MIN <i>0</i> | 2c. DATE PRONOUNCED DEAD
Month <i>Jan</i> Day <i>9</i> Year <i>1968</i> | | 2d. HOUR <i>5:30</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>No. Car.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Student</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Bethesda</i> | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>8507-Rosewood</i> |
| 14. FATHER'S NAME <i>Ralph Gibson</i> | | | 15. MOTHER'S M maiden name <i>Marshall</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>239-76-9659</i> | | 17. INFORMANT <i>father</i> ADDRESS <i>Same as Item 13.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Gun Shot Wound of chest.</i>
<i>9229</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <i>accidental, when playing with gun.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>15 MIN.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>9190</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR <i>4:40</i> P.M. <i>Jan 9 1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Playing with gun, accidently went off.</i> | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)
<i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>8507 Rosewood St.</i> | | City or Town <i>Bethesda</i> | | State <i>Montgomery Md.</i> |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | EXAMINER'S NAME (Type) <i>JOHN G. BALL</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>Jan. 9, 1968</i> |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1-11-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i> | | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | 25a. REC'D BY REGISTRAR <i>JAN 12 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i> | | |

0110

MINISTRY OF DEFENSE

0110

0110

Marshall

22-7-5555 John L. Simpson name as item 13.

22-7-5555 John L. Simpson name as item 13.

0110

MINISTRY OF DEFENSE

0110

0110

3
M

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

27
16
2

X

01158

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01156

| | | | | | | | | | |
|--|--|---|---------------|---|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) | | First
Cora | Middle
Ann | Lost
GILLESPIE | 2a. DATE OF DEATH
January Month 24 Day 1968 Year | | 2b. HOUR
9:26 P | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
March 5, 1876 | | 6. AGE (In years
lost birthday)
91 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital, Bethesda | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Oxon Hill | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5517 Selby Lane | |
| 14. FATHER'S NAME
First
James | | Middle
C | | Last
VARNEY | | 15. MOTHER'S MAIDEN NAME
First
Cecila | | Middle
Connett Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
233-36-9705 | | 17. INFORMANT
210 Portland St. S.E.
Charles R. PAIGE Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
4120
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 24, 1968, to JAN 24, 1968, that (I) (we) last saw the deceased alive on 24 JAN 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles S. Crummy, M.D. | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
26 Jan. 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Charles S. Crummy, M. D. | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION,
BURNING (Specify) | | 23b. DATE
1/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cunningham Memorial Plot | | 23d. LOCATION (City or Town) (County) (State)
Charleston, West Virginia | | | |
| 24. FUNERAL DIRECTOR
TO LEE FUNERAL HOME WASHINGTON, D.C.
FOR BARLOW FUNERAL HOME, CHARLESTON, W. VA. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

0128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01159

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01157

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|--|------------------------------------|--|
| 1. DECEASED NAME
(Type or print)
GLEASON, ELMER E | | | 2a. DATE OF DEATH
Month 1 Day 27 Year 68 | | | 2b. HOUR
2:30 PM | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12-7-1890 | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
District of Columbia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Kensington, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kensington Gardens Saint | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Auto SALESMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
8414 1st Ave. Md. | | | 13b. COUNTY
MONTGOMERY, Md. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3009 McCombs 8914 1st | | | | |
| 14. FATHER'S NAME
First JOSEPH J. Middle J. Last GLEASON | | | 15. MOTHER'S MAIDEN NAME
First A DE LADE C. Middle BROWN Last BROWN | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown No (If yes give war or dates of service) WW I | | | 16b. SOCIAL SECURITY NO.
6-52-01-0725 | | 17. INFORMANT
MARTINA GLEASON Address 304 BRUNNICK DR. 8914-1st Ave. S. 3.7 MI. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200
(b) Systemic Arterial Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years
Years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Myelomelethemia, Generalized Osteoporosis | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1/23/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
- | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
- | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
- | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
123 1965 to 1/27/68 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/23/68 to 1/27/68 , that (I) (we) last saw the deceased alive on 1/27/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
John J. Curry M.D. | | | | | | DEGREE
- | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/27/68 | |
| 22d. PHYSICIAN'S NAME (Type)
John J. Curry M.D. | | | | | | 22e. ADDRESS
10620 Georgetown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | 23b. DATE
1/29/68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Lincoln Crematory | | | 23d. LOCATION (City or Town) (County) (State)
Prince George Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S. Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

01130

01130

01130

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 01160 Item 13 Film G397 1/24/68 kks | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 01158 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>Silver Spring</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of S.S.</u> | | | | | d. STREET ADDRESS <u>2311 N. 9th St.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>SALLY</u> First <u>L.</u> Middle <u>G.</u> Last <u>GLICK</u> | | | | | 4. DATE OF DEATH <u>1-11-1968</u> Month <u>1</u> Day <u>11</u> Year <u>1968</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-7-11</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | | |
| | | | | | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel Mostov Goldberg</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Rose Taube</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NOT AVAILABLE</u> | | 17. INFORMANT Address <u>Holy Cross Hosp. records - Silver Spg., Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis and pulmonary insufficiency</u>
174 x DUE TO <u>Ca of Rt breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u>
(c) <u> </u> DUE TO <u> </u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>> 1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
170 x | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/27, 1967</u> to <u>1/11, 1968</u> that (I) (we) last saw the deceased alive on <u>1/11, 1968</u> , and that death occurred at <u>8:00 P.</u> M, from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>W.Y. Marcus</u> | | | | | 22b. DATE SIGNED <u>1/11/68</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>W.Y. MARCUS, MD</u> | | | | | 22d. ADDRESS <u>10620 Georgia Ave., Silver Spg., Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>JAN. 14/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>—</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>YOUNGSTOWN, OHIO</u> | | | |
| 24. FUNERAL DIRECTOR <u>Thomas M. Hyson</u> ADDRESS <u>Martha W. Hyson & Co. 1300 - N ST. N.W. Wash. DC</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

UNITED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared for release by Medical Examiner

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 01161 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01159 | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Charles Harris Glover | | | | | | 2a. DATE OF DEATH
Month Jan Day 15 Year 68 | | 2b. HOUR
12:35 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12/4/88 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Landscaping | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11 Russell Ave. | |
| 14. FATHER'S NAME First Middle Last
George Glover | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
214-01-5839 | | 17. INFORMANT Address
Medical Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
485X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 497X
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Recent pulm. infarct, ASCVD & CHF</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes. | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-15-68</u> to <u>1-15-68</u> , that (I) (we) last saw the deceased alive on <u>1-15-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Frederick Moomau M.D.</u> | | | | 22c. DATE SIGNED
1-16-68 | | 22d. PHYSICIAN'S NAME (Type)
Frederick Moomau, M.D. | | | |
| 22e. ADDRESS
Medical Center, Sandy Spring, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 18 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg Mont. Md. | | | |
| 24. FUNERAL DIRECTOR
<u>Ernest C. Gartner</u> | | 25. REC'D BY REGISTRAR
JAN 19 1968 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Ernest C. Gartner</u> | | | | | | | | | |

5210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01162

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01160

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) Darlene M. GODFREY | | | 2a. DATE OF DEATH
Month January Day 18 Year 1968 | | | 2b. HOUR
1010PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
May 3 1964 | | 6. AGE (In years lost birthday)
3 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Beauford, S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia | | 13b. COUNTY
Quantico | | 13c. CITY OR TOWN
Quantico | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
Quarters 3602A | | 14. FATHER'S NAME First Middle Last
Gene O. Godfrey | | 15. MOTHER'S MAIDEN NAME First Middle Last
Christine Velasquez | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)
N/A | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT Quantico, Va. Address
SSGT Gene O. Godfrey, USMC Quarters 3602A | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Septicemia, Gram negative
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute Lymphoblastic Leukemia | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
2043 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
<input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that it (this hospital) attended the deceased from January 1, 1968 , to January 18, 1968 , that it (we) last saw the deceased alive on January 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Gene P. Swartz, M.D. | | | | 22c. DATE SIGNED
Jan. 19, 1968 | | 22d. PHYSICIAN'S NAME (Type)
Gene P. Swartz, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Graves, Texas | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Maryland | | | | 25a. REGISTERED BY REGISTRAR
JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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01163

CERTIFICATE OF DEATH

01161

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|------------------------------------|--|
| 1. DECEASED NAME
(Type or print) | | First
Bessie | | Middle
Amory | | Last
Goldsborough | | 2a. DATE OF DEATH
January 15, 1968 | | 2b. HOUR
9:38 P.M. | |
| 3. SEX
Female | | 4. RACE
Caucas | | 5. DATE OF BIRTH
November 2, 1882 | | | | 6. AGE (In years last birthday)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bella Vista Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8614 Garland Avenue | | | |
| 14. FATHER'S NAME First Middle Last
James Cook | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rebecca Amory | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
577-01-9363A | | 17. INFORMANT
Mr. Etney Manuel | | Address
8614 Garland Avenue
Takoma Park, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive Heart Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary Vascular Perfor Disease</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>442X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>442X</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/7</u> , 19 <u>67</u> , to <u>1/15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold Heeger, M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/15/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Harold Heeger M.D.</u> | | 22e. ADDRESS
<u>5415 Conn Ave. N.W. DC</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>Jan 18, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince George County, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Werner E. Pumphrey, Inc.</u> | | ADDRESS
<u>JB Thomas 8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 22 1968</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|---|--|--|
| 011664 CERTIFICATE OF DEATH 011662 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
STELLA KARL GRAHAM | | | | | 2a. DATE OF DEATH Month Day Year
JANUARY 11 1968 | | | 2b. HOUR
7:15AM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
5-19-96 | | 6. AGE (In years last birthday)
71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
AMER. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SAN. & Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BRENTWOOD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3604 WEBSTER ST. | | |
| 14. FATHER'S NAME First Middle Last
HENRY BLANKENSHIP | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Lucretia MAXEY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
579-20-1475 | | 17. INFORMANT
CHART | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1991 IMMEDIATE CAUSE (a) <u>Cardiac failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>advanced carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1992 | | | | | | | | | | | |
| 19a. DATE OF OPERATION
6-27-67 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
partial bowel obstruction | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-10-67, 1967, to 1-11, 1968, that (I) (we) last saw the deceased alive on 1-10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A.W. DANISH, M.D. | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-11-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A.W. DANISH, M.D. | | | | | 22e. ADDRESS
1106 SPRING ST., SILVER SP., MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Home Inc. | | | | | ADDRESS
Valley's Funeral Mt. Rainier, Maryland | | 25a. REC'D BY REGISTRAR
JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

01102

01102

STELLA KARL
FEMALE WHITE
VIRGINIA BORN
2-18-1904

AND A PARK
MAY 1904
HARRY

CHART

CHART

1-11-04

1-11-04

1-11-04

1-11-04

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01165 CERTIFICATE OF DEATH 01163 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) x x x x x x x x x x Lena Miriam Sack Greenspan | | | | | | 2a. DATE OF DEATH
1 Month 4 Day 1968 eor | | 2b. HOUR
11:00 AM | |
| 3. SEX
Female | | 4. RACE
Caus. | | 5. DATE OF BIRTH
9/25/1887 | | 6. AGE (In years lost birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Warsaw, Poland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 1d. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
901 Arcola Ave. University Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Milliner | | 12b. KIND OF BUSINESS OR INDUSTRY
Hat | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2711 Henderson Ave. | |
| 14. FATHER'S NAME First Middle Last
Simcha Geber | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If give war or dates of service) | | 16b. SOCIAL SECURITY NO.
075-20-6831 | | 17. INFORMANT Address
Mrs. Ivan Spear 2711 Henderson Ave. S.S. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
431.9 IMMEDIATE CAUSE (a) BRAIN HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF STROKE SYNDROME
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIO SCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF ARTERIO SCLEROSIS
(c) ARTERIO SCLEROSIS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
MONTHS
YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 7, 1957 to JAN 4, 1968 , that (I) (we) last saw the deceased alive on 1/3/68 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles Farwell, M.D. DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/4/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
CHARLES FARWELL, MD | | | | 22e. ADDRESS
11406 Vices Mill Rd, WHEATON, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
1-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BETH DAVID CEM. | | 23d. LOCATION (City or Town) (County) (State)
ELMONT N.Y. N.Y. | | | |
| 24. FUNERAL DIRECTOR
GOLDBERG FUNERAL HOME 4217 9th St NW | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

0110

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1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01168

01164

| | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Mary Ann Groft | | | 2a. DATE OF DEATH
Month Day Year
January 22 1968 | | | 2b. HOUR
6:10 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1 May 1949 | | 6. AGE (In years
lost birthday)
18 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR
INDUSTRY
None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Pennsylvania | | 13b. COUNTY
New Oxford | | 13c. CITY OR TOWN
New Oxford | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
18 Pleasant Street | |
| 14. FATHER'S NAME First Middle Last
Harold F. Groft | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Carbaugh | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
162-42-8010 | | 17. INFORMANT The Medical Record Address
The Clinical Center, Bethesda, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 12 days
2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2073
(b) <u>Septicemia, probable gram negative</u> 12 days
DUE TO, OR AS A CONSEQUENCE OF
lymph nodes, kidneys, liver & stomach
(c) <u>Acute Lymphocytic Leukemia with involvement of</u> 1-1/3 years | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Leukemic meningitis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>17 July</u> , 19 <u>67</u> , to <u>22 Jan.</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>22 Jan.</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Thomas P. Clancy</u> DEGREE
Thomas P. Clancy, M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
23 January 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas P. Clancy, M.D. | | | | | 22e. ADDRESS
The Clinical Center, National
Institutes of Health, Bethesda, Maryland | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 26, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
New Oxford, Adams Co., Pa. | | | |
| 24. FUNERAL DIRECTOR
<u>Fred F. Feiser</u>
Fred F. Feiser
New Oxford, Penna. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

01186

01186

OFFICE OF DEATH

11-11-50

11 days

11 days

Post-mortem examination of the body of a male, white, 35 years of age, who died of a heart attack on 11-11-50. The body was found in the bathroom of the apartment house at 11-11-50. The cause of death was a heart attack. The body was found in the bathroom of the apartment house at 11-11-50. The cause of death was a heart attack.

Post-mortem examination

James P. Finney, M.D.
James P. Finney, M.D.

11-11-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01167

CERTIFICATE OF DEATH

01165

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) <u>Robert Merle Grow</u> | | | 2a. DATE OF DEATH
Month <u>JANUARY</u> Day <u>27</u> Year <u>68</u> | | | 2b. HOUR
<u>4:05</u> P.M. | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>W</u> | | 5. DATE OF BIRTH
<u>12/17/16</u> | | 6. AGE (In years last birthday)
<u>51</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Michigan</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>St. Mary's</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Night Manager</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Gas Station</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>2302 Homestead Drive</u> | |
| 14. FATHER'S NAME
First <u>James</u> Middle <u>Harold</u> Last <u>Grow</u> | | | 15. MOTHER'S MAIDEN NAME
First <u>Bessie</u> Middle <u>Lucille</u> Last <u>Schalmier</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> <u>World War II</u> | | | 16b. SOCIAL SECURITY NO.
<u>578-03-8156</u> | | 17. INFORMANT
<u>Mabel E. Grow</u> Address <u>2302 Homestead Drive Silver Spring, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebrovascular Hemorrhage</u>
<u>431.9</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>72 hrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>331X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>68</u> , to <u>1-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-27</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>D.L. Bucy</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1-27-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>D.L. Bucy</u> | | | | 22e. ADDRESS
<u>809 W. M. Rd. Rockville Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>Jan. 31, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>C. Glen Carter</u>
<u>Warner E. Humphrey, Inc.</u> | | | | ADDRESS
<u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 30 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "REPUBLIC OF CHINA" and "01161" are visible.]



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01168

Item#15 Film#G397 2/16/68 ph

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01166

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Maurice NMN Crunberg | | | 2a. DATE OF DEATH
Month Day Year
January 26 1968 | | | 2b. HOUR
33 P M | | | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
August 2, 1908 | | 6. AGE (In years last birthday)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San. + Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Research Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt Defense | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
111 Lee Avenue | | | |
| 14. FATHER'S NAME First Middle Last
Chaim Grünberg | | | 15. MOTHER'S MAIDEN NAME First a/k/a Middle Last
Mita Necha OVERBACK Zeiger | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
yes - Army | | | 16b. SOCIAL SECURITY NO.
WWA | | | 17. INFORMANT
Hosp. Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>
410.9 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary artery disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4201 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4100YRS
1945
MONTHS | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-5, 1968, to 1-26, 1968, that (I) (we) last saw the deceased alive on 1-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Albert H. Grollman | | | | DEGREE
MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/26/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ALBERT H. GROLLMAN | | | | 22e. ADDRESS
1106 SPRING ST. SILVER SPRING MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-28-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hyattsville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Bernard Dargatzis & Sons
3301 14th St N.W. Wash. D.C. 20010 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

2110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01169 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01167 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|--------|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First
Marshall | | | | | | | | | | Middle
C. | | | | | | | | | | Last
GUTHRIE | | | | | | | | | | Month
January | | | | | | | | | | Day
29 | | | | | | | | | | Year
68 | | | | | | | | | | 1254 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | | | | | | | | | 4. RACE
Cauc. | | | | | | | | | | 5. DATE OF BIRTH
Apr. 13, 1879 | | | | | | | | | | 6. AGE (In years
last birthday)
88 | | | | | | | | | | YRS. | | | | | | | | | | IF UNDER 1 YEAR
MONTHS | | | | | | | | | | DAYS | | | | | | | | | | IF UNDER 24 HRS.
HOURS | | | | | | | | | | MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Southport N. C. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Physician | | | | | | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Service
Public Health | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | | | | | | | | | 13b. COUNTY
Montgomery | | | | | | | | | | 13c. CITY OR TOWN
Chevy Chase | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
3803 Taylor Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Michael | | | | | | | | | | Middle
C. | | | | | | | | | | Last
GUTHRIE | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
First
Elizabeth | | | | | | | | | | Middle
WILLIAMS | | | | | | | | | | Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO.
212-54-4132-J1 | | | | | | | | | | 17. INFORMANT
Chevy Chase Address
Md.
Dr. Eugene H. Guthrie, 3908 Aspen Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 23, 1968, to Jan. 29, 1968, that (X) (we) last
saw the deceased alive on Jan. 29, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (and) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
William P. Baker
22d. PHYSICIAN'S
NAME (Type) LCDR W.P. BAKER, MC, USN | | | | | | | | | | 22c. DATE SIGNED
Jan. 29, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | | | | | | | 23b. DATE
1-31-1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Washington D. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler & Son
5130 Wisconsin Ave., N.W., Washington, D.C. | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 5 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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CERTIFICATE OF DEATH

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| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>George C Haas</i> | | | 2a. DATE OF DEATH
Month <i>Jan</i> Day <i>27</i> Year <i>1968</i> | | | 2b. HOUR
<i>1:24</i> M | |
| 3. SEX
<i>male</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>May 31 - 96</i> | | 6. AGE (In years last birthday)
<i>71</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>St Paul Minn</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban Hosp</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>US Gov.</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Cherry Chase</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>5510 Cedar Pkw.</i> | | 14. FATHER'S NAME
First <i>George</i> Middle <i>Haas</i> Last <i>Ellen F</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Ellen F</i> Middle <i>Haas</i> Last <i>Facrell</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>220-44-5428</i> | | 17. INFORMANT
<i>Lillian C Haas</i> | | Address
<i>5510 Cedar Pkw</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <i>571.8 Cirrhosis, Liver, marked</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| <i>5810</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 22, 1968</i> , to <i>Jan. 27, 1968</i> , that (I) (we) lost the deceased on <i>Jan. 26</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Marvin Wadler</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/27/68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Marvin Wadler</i> | | | | 22e. ADDRESS
<i>8218 Wisconsin Ave., Bethesda Md</i> | | | |
| 23a. BURIAL, CREMATION, REINTERMENT
<i>Buried</i> | | 23b. DATE
<i>1-31-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Silver Spring Mont Md</i> | |
| 24. FUNERAL DIRECTOR
<i>Robert A Pumphrey</i> | | | | ADDRESS
<i>7557 Wisconsin Ave Bethesda, Md</i> | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 2 1968</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last
John Milton HACKMAN | | | 2a. DATE OF DEATH
January 25 1968 | | 2b. HOUR
1:00 PM | |
| 3. SEX
Male | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
Mar. 28, 1906 | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Naval Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Calif. | | 13b. COUNTY
Alameda | | 13c. CITY OR TOWN
Berkeley | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2909 Forest Ave. | |
| 14. FATHER'S NAME
First Middle Last
John C. Hackman | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
WW II 546-26-1264 | | 17. INFORMANT
Daug.
Lynn Laird | | Address
Same as Item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral infarction, acute</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>332x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Acute myocardial infarction.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Jan. 23</u> , 19 <u>68</u> , to <u>Jan. 25</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Jan. 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John R. Warmolts MD</u> DEGREE | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 26, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
John R. Warmolts | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey | | | | 25a. REC'D BY REGISTRAR
FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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January 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01172 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01170 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|---|--|------------------------|--|--|------------------|--|--|-------|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR P | | | | | | | | | |
| ANNE E. HANKEY | | | | | | | | | | JAN 6 1968 | | | | | | | | | | 1256 M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| FEMALE | | | CAUC | | | 3 JAN 1917 | | | 51 YRS. | | | MONTHS | | | DAYS | | | HOURS | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| MASSACHUSETTS | | | USA | | | | | | MONTGOMERY | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| BETHESDA | | | NAVAL HOSPITAL | | | HOMEMAKER | | | | | | NA | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| VIRGINIA | | | | | | FALLS CHURCH | | | | | | 3129 VALLEY LANE | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EDWARD DEVLIN | | | JULIA LEE | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| NO | | | NA | | | NONE | | | JOHN R. HANKEY | | | FALLS CHURCH, VIRGINIA | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>174X</u> <u>Carcinoma of Breast with Disseminated Metastases.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>170X</u> <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <u>170X</u> <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>26 DEC</u> , 19 <u>67</u> , to <u>6 JAN</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>6 JAN</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. W. Virgilio M.D.</u> | | | | | | | | | | 22c. DATE SIGNED <u>7 JAN 1968</u> | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>R. W. VIRGILIO M.D.</u> | | | | | | | | | | 22e. ADDRESS <u>NAVAL HOSPITAL, BETHESDA, MARYLAND</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | 1-10-68 | | | ARLINGTON, NATIONAL | | | ARLINGTON, VIRGINIA | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| FALLS CHURCH FUNERAL HOME, FALLS CHURCH, VA. | | | | | | | | | | JAN 11 1968 | | | | | | | | | | <u>Charles Judge</u> | | | | | | | | | |

55110

051210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01173 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01171 | | | |
|--|--|--|--|--|--|--|--|------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| CLARA PERRY HANNA | | | | Month 1 Day 13 Year 68 | | | | 7P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | WHITE | | DEC. 10, 1883 | | 8 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| INDIANA | | U.S.A. | | | | MONTGOMERY COUNTY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| TAKOMA PARK, MD. | | OAKHAVEN CONVALESCENT HOME | | HOUSEWIFE | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| D.C. | | - | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3701 Conn. Ave., N.W. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | | | |
| FRANCIS PERRY | | ADELINE GOOD | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address Phone | | | | | |
| no | | 519-60-7960 | | MISS MARY HANNA | | 3701 CONN. AVE. N.W. 244-6295 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 471X | | | | | | | | | | 4-5 day | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Influenzaal Syndrome | | | | | | | | | | 5-7 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| K70X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/11, 1967, to 1/12, 1968, that (I) (we) last saw the deceased alive on 1/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| J. H. Holohom, M.D. | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Charles H. W. Lottan | | 831 Univ Blvd E | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 1-16-1968 | | Cedar Hill Cemetery, | | Suitland, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 24b. REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | | | |
| Joseph Gawler's Sons, Inc. | | 5130 W. Sh. D.C. | | JAN 18 1968 | | Charles J. J... | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the undersigned director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

011774

CERTIFICATE OF DEATH

011772

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) Fred | | | First Middle Last R. Hartschildt | | | 2a. DATE OF DEATH
Month Day Year 1 18 1968 | | | 2b. HOUR
6:45 P M | | | | | |
| 3. SEX
Male | | | 4. RACE
white | | | 5. DATE OF BIRTH
Sept. 27 1879 | | | 6. AGE (in years last birthday)
88 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Kansas | | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Randolph Hills Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Miller | | | 12b. KIND OF BUSINESS OR INDUSTRY
Flour Mill | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Wheaton | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2701 Dawson Avenue | | |
| 14. FATHER'S NAME
George | | | First Middle Last Ludwig | | | 15. MOTHER'S MAIDEN NAME
Katherine Walters | | | First Middle Last Walters | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | | 16b. SOCIAL SECURITY NO.
455-01-6612 | | | 17. INFORMANT
Mr. Maurice Hartschildt | | | Address 591 Dawson Avenue Silver Spring, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-Pneumonia and uric acid
471X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 480X
(b) Influenza.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 day
5 day | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic Heart Disease and Corrupt Hb Phos. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
7:00 PM | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 67 , to January 18, 19 68 , that (I) did saw the deceased alive on January 18, 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Michael R. Dobridge | | | | | | 22c. DATE SIGNED
January 18, 1968 | | | 22d. PHYSICIAN'S NAME (Type)
Michael R. Dobridge | | | | | |
| 22e. ADDRESS
12600 Parkland Drive, Rockville, Md. | | | | | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Jan. 22, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montgomery Md. | | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | | | 25a. REC'D BY REGISTRAR
JAN 23 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

01172

01170



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--------------------------|---|--|--|--|
| 01175 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01173 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | |
| SALLIE | | | M. | | HELBERT | Jan. 27, 1968 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Female | | White | | Oct. 27, 1877 | | 90 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Virginia | | USA | | | | Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rockville | | Home | | Housewife | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | Montgomery | | Rockville | | 908 Lewis Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| Lemuel Stern | | | | | | Rebecca Brock | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | 577-42-2156 | | 1002 Lewis Ave. Ernest F. Helbert Rockville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963, to 1-27, 1968, that (I) (we) lost the deceased alive on 1-27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | |
| D.L. Bucy MD | | 1-27-68 | | D.L. Bucy | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | |
| 809 Kirk Mill Rd | | Mont Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 1/30/68 | | George Washington | | Prince George Co., Md. | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | DATE | |
| Tyson Wheeler | | Pike | | J. Charles Judge | | JAN 30 1968 | |
| Rockville, Md. | | | | | | | |

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• *Journal of Management Education* 25(10):1139-1150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|-------------------------|--|----------|--|------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 01176 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01174 | | | | | | | | | | | | | | | | | | | | | | | |
| Item 13d Film G397 1/25/68 kk | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | | First Middle Last | | | | | | 2a. DATE OF DEATH
Month Day Year | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frances Margaret Hershey | | | | | | | | | | | | January 19 1968 | | | | | | 9:45 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | | White | | | | 25 November 1919 | | | | 48 YRS. | | | | MONTHS DAYS HOURS MIN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Virginia | | | | USA | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | The Clinical Center, NIH | | | | Personnel Supervisor | | | | Government | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | Montgomery | | | | Kensington | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 10907 Newport Mill Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Joseph Rice | | | | | | Annie Shaffer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | 579-12-5399 | | | | | | The Medical Record Address
The Clinical Center, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
425x
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardopathy, Idiopathic
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
4222 Severe Inanition | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | 2 months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | 6 months | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 12/4/67 | | | | | | | | | | | | Pericardial Effusion | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | Yes | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 28 Nov., 1967, to 19 Jan., 1968, that (X) (we) last saw the deceased alive on 19 Jan., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
W. Williams, M.D. | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED
20 January 1968 | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Willis H. Williams, M.D. | | | | | | | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | | 23b. DATE
Jan. 22-1968 | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Oakwood | | | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Halls Church, Va. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Arthur Valters | | | | | | | | | | | | ADDRESS
254 Carroll | | | | | | | | | | | | 25a. REGD BY REGISTRAR
DATE JAN 23 1968 | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
James J. Jones | | | | | | | | | | | |

01116

01116

01116



CERTIFICATE OF DEATH

01177

01175

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Donald Lee Hetherton</u> | | | 2a. DATE OF DEATH
Month <u>January</u> Day <u>13</u> Year <u>1968</u> | | | 2b. HOUR
<u>9:45 AM</u> | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>22 September 1933</u> | | 6. AGE (In years last birthday)
<u>34</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>The Clinical Center, NTH</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Landscaping</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>New York</u> | | 13b. COUNTY
<u>Elmira</u> | | 13c. CITY OR TOWN
<u>Elmira</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<u>1127 Pennsylvania Avenue</u> | | | | | | | |
| 14. FATHER'S NAME
<u>Russell</u> | | | 15. MOTHER'S MAIDEN NAME
<u>Gladys Ogden</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16b. SOCIAL SECURITY NO.
<u>1953-1955</u> | | 17. INFORMANT
<u>The Medical Record</u> Address
<u>The Clinical Center, Bethesda, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>
<u>135X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Peritonitis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Sarcoidosis</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u>
<u>25 days</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>1380</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 Nov.</u> , 19 <u>67</u> , to <u>13 Jan.</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>13 January</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Ira D. Mickenberg, M.D.</u> | | | | 22c. DATE SIGNED
<u>13 January 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Ira D. Mickenberg, M.D.</u> | | | | 22e. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>1-15-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Elmira New York</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey, Bethesda, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 17 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

45110

5110

CERTIFICATE OF DEATH

01173

01176

| | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) <i>Helen</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month <i>1</i> Day <i>5</i> Year <i>1968</i> | | | 2b. HOUR
<i>10:30 PM</i> | | | | | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>8-3-1881</i> | | | 6. AGE (In years
last birthday)
<i>86</i> YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Wash. D.C.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Fairland N.H. Fairland Rd. Silver Spring, Md.</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Homemaker</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Wash. D.C.</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>5010 Arkansas Ave NW</i> | | | |
| 14. FATHER'S NAME
<i>William F.</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
<i>Rebecca Yeakover</i> | | | First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>yes</i> | | | 17. INFORMANT
<i>Alice S. Kenala Silver Spring, Md.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
<i>471 X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <i>470 X</i>
(b) <i>Probable Influenza</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1 WK</i>
<i>10 days</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Arteriosclerotic heart disease, Congestive Heart Failure</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> , 19 <i>67</i> , to <i>1/5</i> , 19 <i>68</i> , that (I) (we) last
saw the deceased alive on <i>1/4</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Raymond T. Benack</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED
<i>1/5/68</i> | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>Raymond T. Benack</i> | | | 22e. ADDRESS
<i>4115 Colie Drive, Wheaton</i> | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>Jan. 8</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Mary's Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D.C.</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner C. Humphrey, Inc.</i> | | | C. Glen Carter
<i>434 Georgia Ave.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 10 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [Signature]</i> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01172

01172

JAN 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|-----------------------------------|---|--|
| 011779 CERTIFICATE OF DEATH 011779 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Samuel Joseph Himmelfarb | | | | | | 2a. DATE OF DEATH
Month Jan Day 28 Year 1968 | | | 2b. HOUR
1 P. | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1887 | | 6. AGE (In years last birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Poland Europe | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bethesda-Silver Spring N.H. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
INVESTMENT BUS. FINANCE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6676-GEORGIA AVE. | | | |
| 14. FATHER'S NAME
FELIX | | First
HIMMELFARB | | Middle
HAARDAH | | 15. MOTHER'S MAIDEN NAME
UNK. | | First
UNK. | | Middle
UNK. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
578-03-3911 | | 17. INFORMANT
ROSE CONED Address
11513 PATAPSCO DR Rockville Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4339
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
5 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17, 1965 , to 1/28, 1968 , that (I) (we) last saw the deceased alive on Jan 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William S. Miller M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/28/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
William S. Miller M.D. | | | | | | 22e. ADDRESS
4201-Corn Ave N.W. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
1-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
DAVID ISRAEL Cem | | 23d. LOCATION (City or Town) (County) (State)
OXON HILL, MD | | | | | |
| 24. FUNERAL DIRECTOR
Soldberg Funeral Home | | ADDRESS
4217-9th St N.W. | | 25a. REC'D BY REGISTRAR
DATE
JAN 31 1968 | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

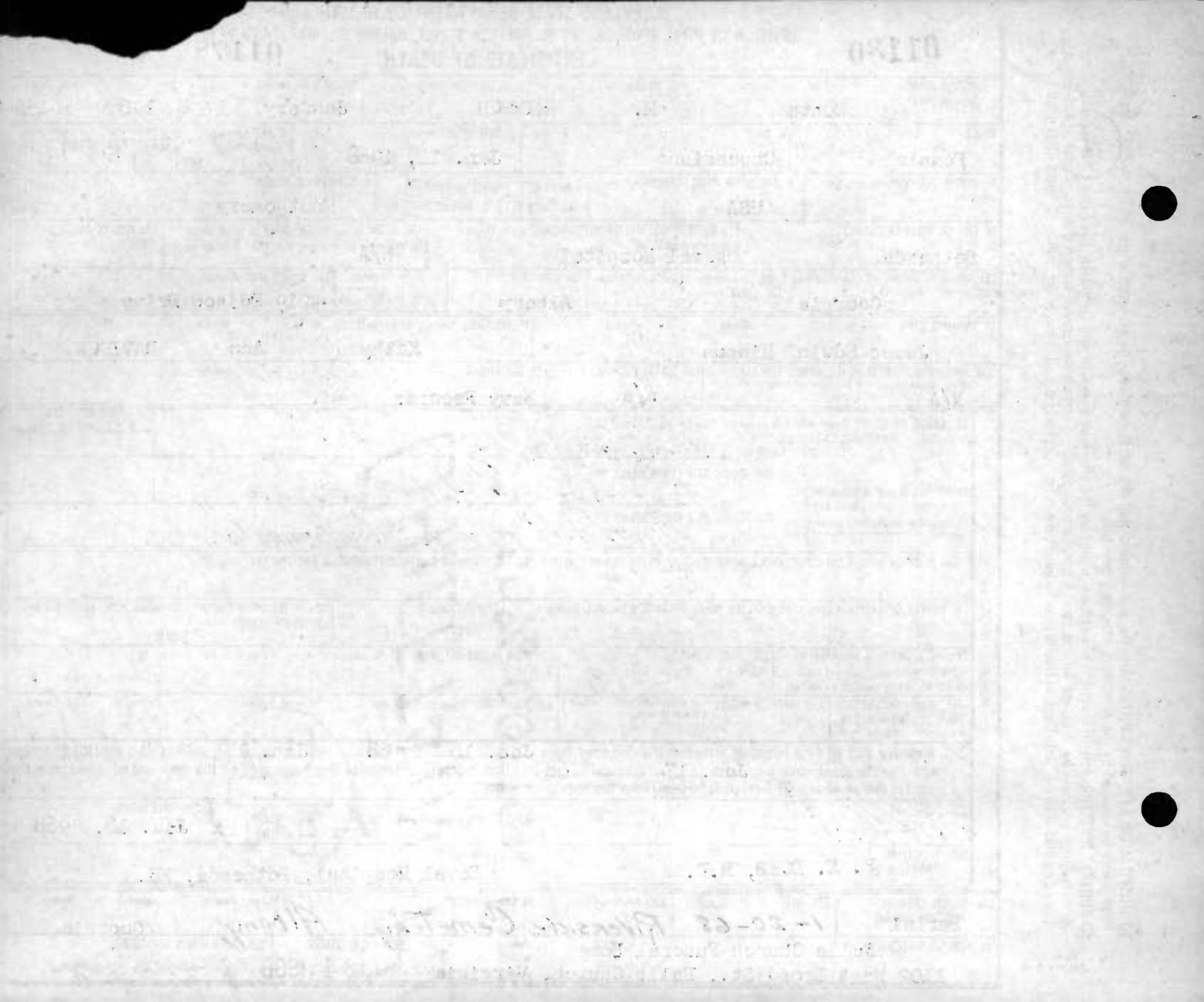
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print)
First Donna Middle M. Last HINSON | | | 2a. DATE OF DEATH
January 17 Day 1968 | | | 2b. HOUR
1015A | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Jan. 11, 1968 | | 6. AGE (In years
lost birthday)
YRS. MONTHS DAYS | | IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
N/A | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Georgia | | 13b. COUNTY
Albany | | 13c. CITY OR TOWN
Albany | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
219 Edison Drive | |
| 14. FATHER'S NAME
First James Edwin Middle Hinson Last | | | 15. MOTHER'S MAIDEN NAME
First Kathy Middle Ann Last DAVISON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
N/A | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT
Address
Navy Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest.</u>
746.2 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Fibrillation of Left.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Multiple Congenital anomalies</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
754.0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 16, 1968, to Jan. 17, 1968, that (I) (we) lost
saw the deceased alive on Jan. 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
Jan. 18, 1968 | |
| 22d. PHYSICIAN'S
NAME (Type) F. X. LOEB, M.D. | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
1-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Riverside Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Albany Georgia | | | |
| 24. FUNERAL DIRECTOR
Falls Church Funeral Home
1102 West Broad St., Falls Church, Virginia | | | | 25a. REC'D BY REGISTRAR
DATE JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
|--|--|---|--|---|--|--|--|
| William Thomas Hobbs | | | | Jan. 30, 1968 | | 10: PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Male | | White | | Sept. 23, 1885 | | 82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Olney | | Montgomery General | | farmer | | farm | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Montgomery | | Silver Spring | | 601 Eldrid Drive | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | |
| Franklin Marion Hobbs | | Martha Elizabeth Johnson | | no | | 218-30-7983 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>436.9</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>10 mo</u>
<u>YRS</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 331X | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/31</u> , 19 <u>68</u> , to <u>1/31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Charles H. Ligon M.D.</u> | | 22c. DATE SIGNED <u>1/31/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| Charles H. Ligon, M.D. | | Sandy Spring, Md. | | Burial | | Feb. 2, 1968 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | |
| Colesville Cemetery | | Colesville, Maryland | | Thomas J. Burns | | DATE FEB 5 1968 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | | 25e. REGISTRAR'S SIGNATURE | |
| Warner E. Pumphrey, Inc. | | Silver Spring, Md. | | Charles Judge | | | |

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RECORD OF DEATH

DATE OF BIRTH

PLACE

DATE OF DEATH

PLACE

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print)
August Hohenstein | | | | | | 2a. DATE OF DEATH
Month Jan. Day 4 Year 1968 | | | 2b. HOUR 11:55 PM | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
7/8/1868 | | 6. AGE (In years lost birthday)
99 YRS. | | IF UNDER 1 YEAR
MONTHS 99 DAYS 99 | | IF UNDER 24 HRS.
HOURS 99 MIN 99 | |
| 7a. BIRTHPLACE (State or foreign country)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chevy Chase Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ins. Broker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5200 Camberly Avenue | |
| 14. FATHER'S NAME First Adam Middle Hohenstein Last | | | | 15. MOTHER'S MAIDEN NAME First unobtainable Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
475-22-3353 | | 17. INFORMANT Address
Home Records same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF
(c) Unknown | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
4201 Fracture R+Hip | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 67 , to Present 19 68 , that (I) (we) last saw the deceased alive on Jan 4 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George D. Sharpe | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
George D. Sharpe, M. D. | | | | 22e. ADDRESS
10511 Summit Ave. Kensington, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
1/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State)
St. Paul, Minnesota | | | |
| 24. FUNERAL DIRECTOR
The S.H. Hines Co. Washington, DC. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

CLEARED WITH CORONER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|---|--------------------------------------|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>MARGUERITE A. HOJSGAARD</i> | | | | | | 2a. DATE OF DEATH
Month <i>January</i> Day <i>14</i> Year <i>1968</i> | | | 2b. HOUR
<i>5³⁰ PM</i> | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>CAUC.</i> | | 5. DATE OF BIRTH
<i>3-11-88</i> | | | 6. AGE (In years last birthday)
<i>79</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS <i>79</i> DAYS <i>79</i> | | 8. IF UNDER 24 HRS.
HOURS <i>79</i> MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>WASH D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>MONTGOMERY</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>SILVER SPRING</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>FAIRLAND NURSING HOME</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>WESTERN UNION</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>BETHESDA</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>7809 TILBURY ST.</i> | | | |
| 14. FATHER'S NAME First Middle Last
<i>JOSEPH PHILIP SAGRARIO</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>JOSEPHINE ?</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO.
<i>578-0351-58A</i> | | 17. INFORMANT Address
<i>INFORMATION TAKEN FROM CHART.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>
<i>4369</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Generalized arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>331X</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1967</i> , to <i>Jan 14, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 11, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Boris Rabkin MD</i> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Jan 14, 1968</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>BORIS RABKIN</i> | | | | | | 22e. ADDRESS
<i>1019 University Blvd East Stirling</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1-17-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rockville Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 18 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01182

| | | | | | | | | | | |
|--|---------|--|--------|--|--------------------------|---|---|---|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> Month | Day | Year | 2b. HOUR |
| RALPH W HORTON | | | | | JAN 1 1968 | | | | | 2:27 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| M | W | MAY 19-1908 | | 59 YRS. | MONTHS DAYS | | HOURS MIN. | | Month JAN Day 1 Year 1968 2:27 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| ORFORD N.H. | | U.S.A | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | BETHESDA Rd | | | | Ass Chie/Clerk-Comm Comm | | U.S. Senate | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | Montgomery | | BETHESDA | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5517 GLENWOOD Rd. | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| WILLIAM L. HORTON | | | | | HARRIET WEBSTER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| YES | | WW II | | 001-05-5502 | | CHARLOTE N HORTON SAME. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction. Acute - | | | | | | | | | | Sudden. |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Coronary Insufficiency Severe - | | | | | | | | | | Years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Cardio Vascular Disease - | | | | | | | | | | Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | JOHN G. BALL | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | JOHN G. BALL | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 1 Jan. 1968 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Bethesda, Md. | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 1-3-68 | | Culpepper Natl Cem. | | Culpepper, Virginia | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | DATE JAN 5 1968 | | John G. Ball | | |

SAITO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>01185</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01183</div> | | | | | | | | | |
|--|--|--|---|--|---|---|--|------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P |
| Lawrence | | | Cletus | | | Howard | | | January 23, 1968 4:10 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| Male | | White | | 6 March 1921 | | | 46 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Missouri | | USA | | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | The Clinical Center, NIH | | | Truck driver | | | Transport |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Missouri | | | | | Salisbury | | | Route 1, Box 6 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Benjamin | | | Howard | | | Mary Baldridge | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| Yes | | | WW II | | The Medical Records Address 20014
The Clinical Center, Bethesda, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | | | | | | | 48 Hours |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hodgkin's Disease</u> | | | | | | | | | 14 Months |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Cholecystitis, Emphysema</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 5, 1967</u> , to <u>Jan. 23, 1968</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 23, 1968</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | MD DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>John W. Keys, Jr.</u> | | | | | | | | 24 January 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | | John W. Keys, Jr., MD. | | | 22e. ADDRESS The Clinical Center, National 20014
Institutes of Health, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 1-26-68 | | East Lawn Mem. Garden | | | Salisbury, Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Md. | | | | | FEB 2 1968 | | <u>[Signature]</u> | | |

81110

RECEIVED

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1-20-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 115 (4)
30M REV 11-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01186 | | | | | | | | | |
| 01184 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| KATHERINE | | | HUGHES | | | Month Day Year
January 4 68 | | | 2:25 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | | W | | JAN. 9, 1889 | | 78 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| UNKNOWN | | U.S.A. | | | | MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | | | CHEVY CHASE NURSING & CONV CENTER | | | HOUSEWIFE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| D.C. | | | V | | WASHINGTON | | YES | | 2230 CALIFORNIA ST., N.W. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JOHN LEECH | | | MARGARETTA PARK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| NO | | | | | | M.H. RECORDS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4339 Multiple Cerebrovascular Thromboses
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral arteriosclerosis, advanced
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis, generalised
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Auricular Fibrillation, chronic 5 yrs + | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Aug 1964
5 yrs +
5 yrs + |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1947, to Jan 4, 1968, that (I) (we) last saw the deceased alive on Jan 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stewart Clapp M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 4, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Stewart Clapp M.D. | | | | | | 22e. ADDRESS 4740 Chevy Chase Dr. Chevy Chase Md 20015 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| CREMATION | | | 1/6/68 | | CEDAR HILL CREM. | | SUITLAND, MD. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| JOS. GAWLER'S SONS, WASH., D.C. | | | | | | DATE JAN 10 1968 | | Charles J. [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|
| 1M 01187 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01185 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Russell Thomas Hungerford | | | | | | | | | | 2a. DATE OF DEATH
1 Month 8 Day 68 Year | | | | | | | | | | 2b. HOUR
11:59 AM | | | | | | | | | |
| 3. SEX
male | | | | | 4. RACE
white | | | | | 5. DATE OF BIRTH
September 9, 1874 | | | | | 6. AGE (In years last birthday)
93 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wheaton Nursing Home | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CLERK | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
STATE BUS. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Washington, D.C. | | | | | 13b. COUNTY
— | | | | | 13c. CITY OR TOWN
Washington | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
3820 Kanawha | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Thomas W. Hungerford | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Carric Blanchard | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Unknown No | | | | | 16b. SOCIAL SECURITY NO.
UNKNOWN | | | | | 17. INFORMANT
Decedant Address | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Consecutive heart failure</u>
412.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arteriosclerotic cardiovascular disease 3 yrs</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOV</u> , 19 <u>63</u> to <u>JAN</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>7 JAN</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Walter E. Goozh</u> | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
1/8/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Walter E. Goozh | | | | | | | | | | 22e. ADDRESS
2309 Shorefield Rd., Wheaton, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
1/12/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., Wash., D. C. | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01188

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01186

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>WASH.</u> b. COUNTY <u>PRINCE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. LENGTH OF STAY IN TB
<u>5 wks.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>1517 1/2 MOUNTAIN VIEW AVE Washington, DC</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home</u> | | | | d. STREET ADDRESS <u>1537 Monroe St. N.W.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Emma</u> Middle <u>A.</u> Last <u>HUNTER</u> | | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>28</u> Year <u>1968</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-15-1875</u> | | 9. AGE (In years last birthday)
<u>92</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Singleton Atchison</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Julia Ann Marsh</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
Address
<u>Wm. Franklin McDonald 3907 Windy Lane Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerotic Heart disease</u>
DUE TO
(c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12-2-67 (2 mo)</u>
<u>25 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>4200</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-20, 1968</u> to <u>12-28, 1968</u> that (I) (we) lost saw the deceased alive on <u>1-28, 1968</u> , and that death occurred at <u>11:30 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Louis Gillespie, Jr.</u> | | | | 22b. DATE SIGNED
<u>1-29-68</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>LOUIS GILLESPIE, JR.</u> | |
| 22d. ADDRESS
<u>1716 N ST. N.W. WASH. D.C.</u> | | | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>1/31/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges Co. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>The H. Hine Co. 2901 14th St. N.W.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 31 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

UNITED

DEPARTMENT OF AGRICULTURE



UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1917

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BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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WASHINGTON, D. C.

1/31/16

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01189

01187

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN lb
8 HOURS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SAN. & HOSP. | | | | d. STREET ADDRESS
2101 FAIRLAND ROAD | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
BESSIE MAUDE HURLEY | | | | 4. DATE OF DEATH
Month Day Year
JANUARY 1 1968 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-20-78 | |
| 9. AGE (In years last birthday)
90 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HOME | | 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | |
| 13. FATHER'S NAME
CHARLES PRATHER | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
HOSP. RECORDS | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 412.9 Acute Bilateral Lobar
DUE TO (b) Pneumonia
DUE TO (c) Arteriosclerotic Heart Disease | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
4200 | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | | 22. DATE SIGNED
JAN. 1, 1968 | | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Jan 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington D. C. | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CHARLES SPENCER HYSON | | | | | | 2a. DATE OF DEATH 1 Month 21 Day 68 Year | | 2b. HOUR 7:30 P.M. | |
| 3. SEX M | | 4. RACE NEGRO | | 5. DATE OF BIRTH 3-25-83 | | 6. AGE (In years last birthday) 87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SP. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 200 BURST MILLS AVE | |
| 14. FATHER'S NAME First Middle Last SPENCER HYSON | | 15. MOTHER'S MAIDEN NAME First Middle Last HARRIET BOWIE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN | | 16b. SOCIAL SECURITY NO. 212-14-9461 | | 17. INFORMANT GRANDDAUGHTER Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pericarditis
5621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(c) Perforated Ileal Diverticulitis
10da. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
1 wk | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
5721 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October, 1935 , to 1-21-1968 , that (I) (we) last saw the deceased alive on 1-20-68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE James H. [Signature] | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-21-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS 777 small ave Takoma Park Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 1-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY High Memorial Cem. | | 23d. LOCATION (City or Town) (County) (State) Sandy Spring, Montg, Md. | | | |
| 24. FUNERAL DIRECTOR George R. Morden | | ADDRESS Rockville Md | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 24 1968 | |

01180

01180

REPUBLIC OF CHINA

CHINESE GOVERNMENT

1948

01189
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7a, 7b, 10 & 11 Film G396
1/11/68 kx
CERTIFICATE OF DEATH

01189

| | | | | | | | | | | | |
|--|--|-------------------------------------|---|---|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
JOHN INNOCENTI | | | 2a. DATE OF DEATH
Jan. Month 3 Day 68 Year | | 2b. HOUR
: 54 A M | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
5/5/1883 | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Montg. Cty | | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12624 Farnell Dr. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic Heart Disease</u>
4201
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>Yes.</u>
<u>Yes</u> | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-5</u> , 19 <u>67</u> , to <u>1/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-2-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Francis X. Richardson</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/3/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
FRANCIS X. RICHARDSON | | | | | | 22e. ADDRESS
11412 Viers Mill Rd., Wheaton Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
<u>6 Jan 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Wheaton</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Wheaton Md</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Ronald J. Zurek</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 8 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CONCLUSION

of

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2000 年 12 月 10 日

1. The first step is to identify the problem or goal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01192

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01190

| | | | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) Franklin E. Jackson | | | 2a. DATE OF DEATH
Month 1 Day 19 Year 68 | | | 2b. HOUR
M 68 | | | | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
5-22-67 | | 6. AGE (In years last birthday)
7 YRS. | | IF UNDER 1 YEAR
MONTHS 7 DAYS 7 | | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN Boyd's | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First Frank Middle Jackson Last N | | | 15. MOTHER'S MAIDEN NAME First Alverta Middle Sewell Last S | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
517X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CHRONIC PULMONARY FIBROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) PREMATURITY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 DAYS
MONTHS
8 MONTHS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
7735 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
3:35 P.M. JAN 19 1968 | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
3:35 P.M. JAN 19 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV. , 19 67 , to JAN. 19 , 19 68 , that (I) (we) lost the deceased alive on JAN. 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward J. Feroli | | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/20/68 | |
| 22d. PHYSICIAN'S NAME (Type)
EDWARD J. FEROLI | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
1-23-68 | | 23c. NAME OF CEMETERY OR CREMATORY
MT ZION CEM. | | | 23d. LOCATION (City or Town) (County) (State)
BARNESVILLE Md. | | | |
| 24. FUNERAL DIRECTOR
George R. Snowden | | | | | | ADDRESS
Rockville Md. | | 25a. REC'D BY REGISTRAR
18 JAN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

01130

STATE OF TEXAS

01130



CERTIFICATE OF DEATH

01193

01191

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Jenkins | | | 2a. DATE OF DEATH
Month Day Year
January 19 1968 | | | 2b. HOUR
2:50 P.M. | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
January 18, 1968 | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS
1 9 21 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Adelphi | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
8103 20th Ave | | 14. FATHER'S NAME
First Middle Last
Lester Booth Jenkins | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Lindell Woodward | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
mother | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Hyaline Membrane Disease</u>
7761
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
7735 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 18, 1968</u> , to <u>Jan 19, 1968</u> , that (I) was last saw the deceased alive on <u>Jan 18, 1968</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Stanley H. Steinberg, MD</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/31/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>STANLEY H. STEINBERG, MD</u> | | 22e. ADDRESS
<u>1040 UNIV. BLVD, E. SIL SPR, MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>2/5/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home</u> | | 24b. ADDRESS
<u>Rock Pike</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE
<u>FEB 8 1968</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12110

12110

12110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01194

CERTIFICATE OF DEATH

01192

| | | | | | | | |
|---|--|--|--------|---|---------------------------|--|----------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR |
| Ida | | | L. | Johannes | 1/21/68
Month Day Year | | 2 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Female | | Caucasian | | March 10, 1872 | | 95 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Cincinnati, Ohio | | U.S.A. | | | | Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | Oak Haven Nursing Home | | Homemaker | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 807 Gist Avenue | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | |
| Frank | | | Lane | | Elizabeth Glendenny | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | Yes | | Ethel L. Johannes 807 Gist Avenue Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pulmonary edema</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hrs
3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15/62, 19__, to 1/21, 1968, that (I) (we) last saw the deceased alive on 1/21/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Patrick Jameson | | | | | | 1/22/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Patrick Jameson | | 11718 Georgia Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Trans-burial | | Jan. 23, 1968 | | Memorial Park Cemetery | | Sedalia, Missouri | |
| Funeral Director | | Glen Carter | | 8434 Georgia Avenue | | DATE JAN 25 1968 | |
| Warner E. Pumphrey, Inc. | | Silver Spring, Maryland | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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VR A15 (4)
30M REV. 1/68

| 01195 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01193 | | | | | |
|--|--|--|--|--|---|---|-------------------------------------|--|-----------------------------------|--|------------------|--------|------|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | | 2b. HOUR | | |
| ELINOR F. | | | | | | JOHNSON | JANUARY 15 68 | | | | 12 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | Cauc. | | Mar. 4, 1913 | | | 54 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Washington, D.C. | | U. S. | | | | Montgomery Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Kensington | | | Carroll Hall | | | None | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Dist. of Col. | | | Washington | | | | | | | 16th & Irving Sts. N.W. | | | |
| 14. FATHER'S NAME | | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Last |
| James H. Johnson | | | | | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | | |
| No | | | | None | | Carroll Hall Records | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410.0 CORONARY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) HYPERTENSIVE CARDIOVASCULAR DISEASE 15 YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HOUR | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 2, 1952, to January 15, 1968, that (I) (we) last saw the deceased alive on January 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas S. Sappington M.D. | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/15/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas S. Sappington | | | | | | 22e. ADDRESS
2233 Wisconsin Ave. N.W. | | | | | | | |
| 23a. BURIAL CREMATION
<input checked="" type="checkbox"/> BURIAL (Specify) | | | 23b. DATE
Jan. 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25. READ BY REGISTRAR
DATE JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01196

01194

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Beltsville</u> | | c. LENGTH OF STAY IN TB
<u>70 DAYS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Randolph Hills Nursing Home</u> | | | | d. STREET ADDRESS
<u>13200 Darnestown Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>First Edward Johnson</u> Middle Last | | | | 4. DATE OF DEATH
Month <u>Jan</u> Day <u>6</u> Year <u>1968</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 9, 1890</u> | 9. AGE (In years lost birthday) yrs.
<u>77</u> | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Rex Clay Products</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Nils Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise Jacobson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>366 05 0679</u> | | 17. INFORMANT
<u>Mrs. Louise C. Anderson Gaithersburg, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO (b) <u>Probable Influenza</u>
DUE TO (c) <u>480X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>471X</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebral Arteriosclerosis</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> , 19 <u>61</u> , to <u>1/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>68</u> , and that death occurred at <u>2:50 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Raymond T. Benack</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>1/6/68</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Raymond T. Benack</u> | | | | 22d. ADDRESS
<u>4115 Colie Drive, Wheaton Md</u> | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>Jan. 9, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Acacia Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Royal Oak, Michigan</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey</u> | | | | ADDRESS
<u>Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AN 11 1968</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | |

MEDICAL CERTIFICATION

01110

FORWARD OF DATA

01110

ROYAL OCEAN, N. O. 1008

ROYAL OCEAN, N. O. 1008

ROYAL OCEAN, N. O. 1008

1008

ROYAL OCEAN, N. O. 1008

ROYAL OCEAN, N. O. 1008

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------|--|------------------|--|-------------------------------|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First
Vincent | Middle
Eugene | Last
Johnson, Jr. | | 2a. DATE KNOWN OF DEATH
Month Jan. Day 10 Year 1968 | | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
8/21/67 | | 6. AGE (In years lost birthday)
YRS 4 MONTHS 20 | IF UNDER 1 YEAR
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Jan. Day 10 Year 1968 | | 2d. HOUR
9:50 AM | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
D.O.M. Montgom. Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Infant | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Cooksville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Route 97, Box. 2 | |
| 14. FATHER'S NAME
First Vincent Middle Eugene Last Johnson | | 15. MOTHER'S MAIDEN NAME
First Peggy Middle Bernice Last Bowens | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
ADDRESS
Medical Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crib Death, etiology unknown
778.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
7730 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Read | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
JAN. 10, 1968 | |
| EXAMINER'S NAME (Type)
BELDEN R. READ, M.D. | | ADDRESS
Cooksville, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS
Cooksville, Md. | | 22c. REGISTRAR'S SIGNATURE
Harry W. Haight | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-12-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Bushey Park | | 23d. LOCATION (City or Town) (County) (State)
Cooksville Md. | | 25a. REC'D BY REGISTRAR
DATE JAN 16 1968 | |
| 24. FUNERAL DIRECTOR
Harry W. Haight | | ADDRESS
Lynchville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TOXICITY
REPORT

0137

0137

Jan. 10 '68

Contract, 77.

Agent

Agent

Jan. 10 '68

1-20

SAVET

SAVET

SAVET

Person

Person

Person

U.S.A. Mountain, 2nd. 1000 ft.

Person

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

Person 27, 1st. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01193 | | | | | | | | | |
| 01196 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M |
| JONES, ALICE M | | | | | | JAN 13 68 | | | |
| 3. SEX
FEMALE | | 4. RACE
NEGROID | | 5. DATE OF BIRTH
15 SEPT 32 | | | 6. AGE (In years
last birthday)
35 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign
country)
Philadelphia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
332 SUTTER RD. | |
| 14. FATHER'S NAME
First Middle Last
Timothy Vance | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
204-24-2854 | | 17. INFORMANT
Address
Mr Walter Z. Jones 332 Suter Rd. Catonsville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA WITH SEPSIS</u>
481X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
490 | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12 JAN</u> , 19 <u>68</u> , to <u>13 JAN</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>13 JAN</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Jack E. Zimmerman</u> | | | | DEGREE
M.D. | | ATTENDING
PHYS.
<input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
15 JAN 68 | |
| 22d. PHYSICIAN'S
NAME (Type)
JACK E. ZIMMERMAN M. D. | | | | 22e. ADDRESS
NAVAL KM HOSPITAL, BETHESDA MD. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
1/20/68 | | 23c. NAME OF CEMETERY OR INSTITUTION
BALTIMORE NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, KM MD BALTIMORE, MD | | | |
| 24. FUNERAL DIRECTOR
NUTTER FUNERAL HOME, 3035 W. NORTH AVE | | | | 25a. REC'D BY REGISTRAR
DATE JAN 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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Y

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|------------------------------|--|---|----------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 011997 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| JAMES HAMPTON JONES | | | | | | JAN Month 25 Day 68 Year 905 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| MALE | | WHITE | | 5/9/16 | | 51 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | | | SUBURBAN | | | OFFICE MANAGER | | | CASEY Eng. Co. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | MONTGOMERY | | Gaithersburg | | | 16632 ALDEN AVE. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| JAMES H. JONES | | | | | | Ethel PATE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| yes | | | WW II | | | BARBARA - WIFE - SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary insufficiency, descending branch sudden | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary arteriosclerosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| Fistula, entero-vesicle (Diverticula) with partial intestinal obstruction. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 1-22-68 | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-17, 1968, to 1-25, 1968, that (I) (we) last saw the deceased alive on 1-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | ATTENDING PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | 22c. DATE SIGNED | |
| J.P. McCARRICK M.D. | | | | | | | | 1-25-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| J.P. McCARRICK M.D. | | | | | 809 VIER'S MILK RD ROCKVILLE MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-27-68 | | St. Rose | | Gaithersburg, Montg. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Ernest C. Gartner. Gaithersburg, Md. | | | | | DATE JAN 29 1968 | | Charles Judge | | |

01110

CERTIFICATE OF DEATH

01110

x

01200

CERTIFICATE OF DEATH

01198

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) MARY LOUISE JOYCE | | | 2a. DATE OF DEATH
Month Jan Day 28 Year 1968 | | | 2b. HOUR
7:30 M | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
1/31/06 | | 6. AGE (In years
last birthday)
61 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Massachusetts | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done,
during most of working life, even if retired.)
Teacher | | 12b. KIND OF BUSINESS OR
INDUSTRY
Public School | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
9504 Riley Rd | |
| 14. FATHER'S NAME First Middle Last
Edward J. Carlson | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Murphy | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
457-38-5961 | | 17. INFORMANT
Raymond Gable | | Address
1828 Jefferson Place, N. W.
Washington, D. C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 174X INANITION & STARVATION
DUE TO, OR AS A CONSEQUENCE OF BONE & VISCERA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA, WIDESPREAD, TO
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA (R) BREAST, SURGICALLY REMOVED | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 MONTHS
9 MONTHS
3 1/2 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (g)
170X | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
— | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.)
— | | 21f. LOCATION Street or R.F.D. No. City or Town County State
— | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL , 19 64 , to JAN 28 , 19 68 , that (I) (we) last
saw the deceased alive on JAN 27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Frederick S. Calowell MD | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/28/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type) FREDERICK S. CALOWELL | | | | 22e. ADDRESS
TENNEY BLVD
ROCKVILLE, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 31, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR
Shirley Thomas John B. Thomas | | | | ADDRESS
434 Georgia Ave.
Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
DATE JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01200

01102

01102

01102

CLEAR with Medical Examiner, L.S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|--|--------------------------------|---|--------------------------------|--|
| Items 1-19a&20 Film 397 MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01199 | | |
| 01201 | | | | | | | | | | | | CERTIFICATE OF DEATH | | |
| 1. DECEASED-NAME (Type or print) IRENE LOUISE | | | | | | First (SCHAEFER) Middle (KEENAN) Last KEENAN | | 2a. DATE OF DEATH
1 Month 8 Day 68 Year | | | | 2b. HOUR
9:25 P.M. | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
10-8-92 | | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASH. SAN. & Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSE WIFE & SALES | | | | 12b. KIND OF BUSINESS OR INDUSTRY
WOMEN | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN HYATTS. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2013 POWHATAN ST. | | | | |
| 14. FATHER'S NAME First WILLIAM Middle SCHAEFER Last | | | | | | 15. MOTHER'S MAIDEN NAME First GERTRUDE Middle RUPPERT Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
579-34-8071 | | 17. INFORMANT
Hosp. Records. Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dissecting aortic aneurysm
441.0
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic vascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 hours
20 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
451X | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
 | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 , to 1/8 , 19 68 , that (I) (we) last saw the deceased alive on 1/8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Hugh J. Fry | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
HUGH J. FRY, MD | | | | | | 22e. ADDRESS
1161 NH AVE SIL SPR MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
 | | | 23b. DATE
1-11-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
ST MARYS CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
WASH, D.C. | | | | | |
| 24. FUNERAL DIRECTOR
W W Chambers | | | | | | ADDRESS
1400 Chapin St NW WASH D.C. | | 25a. REC'D BY REGISTRAR
JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

07510

2007-2008

01202

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01200

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|--|--|--|--|--|--|---|--|------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | |
| ARTHUR THOMAS KEENE | | | | | | | | M <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> 68 | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| M | WHITE | Z-15-98 | | 76 YRS. | | MONTHS DAYS | | HOURS MIN | | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> 68 | | M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| VIRGINIA | | USA | | | | MONTGOMERY | | Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| TAKOMA PARK | | WASH. SAN. E. HOSPITAL | | SALESMAN | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | |
| MD | | PRINCE GEORGES | | ADELPHI | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 8113 15TH AVE | | APT 104 | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| James | | o | | Keene | | | | Betty | | Dodson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| YES | | WWI | | | | WIFE | | SAME | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>PULMONARY EMPHYSEMA</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | JAN. 5, 1968 | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | | ADDRESS (City or Town, County) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 1/9/68 | | | | Rock Creek Cemetery | | | | Washington D.C. | | | |
| 24. FUNERAL DIRECTOR <u>W.K. Huntemann & Son</u> Address <u>5732 Ga Ave N.W.</u> | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Funeral Home. <u>W. K. Huntemann</u> | | | | DATE <u>JAN 10 1968</u> | | | | <u>Charles Judge</u> | | | | | | | |

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01505

Arthur - Thomas - Kline

M. White & Co. Inc.

X

Virginia

Florida

James H. White & Co. Inc.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01201

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Charles Julian Keeth Sr. | | | 2a. DATE OF DEATH
Month January Day 26 Year 1968 | | | 2b. HOUR 11:35 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 5, 1906 | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Louisiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San. & Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Stand. Oil | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
711 Dartmouth Avenue | |
| 14. FATHER'S NAME First Middle Last
Rudolph Keeth | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Jannie Sanders | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Mary Jane Keeth | | Address
711 Dartmouth Ave. S.S. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 hours.
Known
12 months. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 21, 1963 , to Jan 26, 1968 , that (I) (we) last saw the deceased alive on Jan 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Aaron H. Traumm M.D. DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 27 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Aaron H. Traumm M.D. | | | | | 22e. ADDRESS
8237 Georgia Ave Silver Spring Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montgomery Md. | | | |
| 24. FUNERAL DIRECTOR
C. Glen Carter
Valner E. Pumphrey Inc. 8434 Georgia Avenue SS | | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| DATE
JAN 30 1968 | | | | | | | | | |

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>
c. LENGTH OF STAY IN b. <u>15 YEARS</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13104 Matey Road</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>
d. STREET ADDRESS <u>13104 MATEY ROAD</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>ANNA WILHELMINA KELLY</u>
First Middle Last
4. DATE OF DEATH <u>JAN 19 1968</u>
Month Day Year | | | 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 13 - 1908</u>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>CHICAGO ILL.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>
12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME <u>HENRY Z. VAN REIN</u>
14. MOTHER'S MAIDEN NAME <u>ANNA AUKER</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)
16. SOCIAL SECURITY NO. <u>368-22-2417</u>
17. INFORMANT <u>MILTON BRAMAN 2710 CEDAR AVE LONG BEACH, CAL.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>
<u>153.8</u> DUE TO (b) <u>CANCER OF COLON & LEFT KIDNEY</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1992</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-10 1966</u> , to <u>1-19 1968</u> , that (I) (we) last saw the deceased alive on <u>1-17 1968</u> , and that death occurred at <u>6:PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Sarah E. Glover</u>
22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>1-19-68</u>
22d. ADDRESS <u>10128 CEDAR LAKE KENSINGTON MD</u>
22b. DATE SIGNED | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>1-23-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>
ADDRESS | | | | | |
| 25a. REC'D BY REGISTRAR <u>JAN 24 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
DATE | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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15104 Intev Road



Vertical text on the right margin, likely a filing or processing stamp.

Main body of the document containing multiple lines of text, possibly a list or report. The text is mostly illegible due to blurring and low contrast.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-64
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|----------------------------------|--|--|--------------|--|--|---------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Ernest L. | | | Middle
L. | | | Last
Kelly | | | 2a. DATE OF DEATH
Month
Jan. | | | Day
7 | | | Year
1968 | | | 2b. HOUR
5:50 PM | | |
| 3. SEX
Male | | | 4. RACE
W | | | 5. DATE OF BIRTH
Dec. 9, 1914 | | | 6. AGE (in years
last birthday)
53 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 HRS.
HOURS
MIN | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
W. Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
mech. Contractor | | | 12b. KIND OF BUSINESS OR
INDUSTRY
E.L. Kelly and Son | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
308-Hamilton Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME
First
James L. | | | Middle
L. | | | Last
Kelly | | | 15. MOTHER'S MAIDEN NAME
First
Mary | | | Middle
Kneon | | | Last
Kneon | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Mrs. Bernice Kelly | | | Address
308-Hamilton Ave. S. Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepaticoma
157.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Pancreas
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week.
1 year. | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
157.8 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September, 1967, to Jan 7, 1968, that (I) (we) last saw the deceased alive on Jan 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | DEGREE
BLAINE H. EIG | | | ATTENDING PHYS.
[Signature] | | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
Jan 7, 1968 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
BLAINE H. EIG | | | 22e. ADDRESS
9801 Bergman Road, Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Jan 10-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
John W. [Signature] | | | ADDRESS
544 CHASE ST. | | | 25a. REC'D BY REGISTRAR
JAN 10 1968 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01206 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01204 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EVELYN L. KEMP | | | | | | | | | | 1 11 68 | | | | | | | | | | 2:28 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | 8/1/83 | | | | | | | | | | 84 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kirksville, Mo. | | | | | | | | | | U.S.A. | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | | | | | | | Bethesda Silver Spring | | | | | | | | | | School teacher-D.C. Schools | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if in institution before admission) STATE | | | | | | | | | | 13b. CITY OR TOWN | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | Washington, D.C. | | | | | | | | | | | | | | | | | | | | 3701 Conn. Ave. N.W. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J.T. Kemp | | | | | | | | | | Lulu Smith | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 579-60-0472 | | | | | | | | | | Isabel C. Pryce-4411 | | | | | | | | | | Washington, D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 | | | | | | | | | | Congestive Heart Failure | | | | | | | | | | 7 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 13, 1967, to Jan 11, 1968, that (I) (we) last saw the deceased alive on Jan 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neil P. Campbell | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1/11/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neil P. Campbell | | | | | | | | | | 1629 Columbia Rd. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| burial | | | | | | | | | | 1/13/68 | | | | | | | | | | Rock Creek Cemetery | | | | | | | | | | Washington, D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The S.H. Hines Company | | | | | | | | | | 2901 14th St. N.W. Washington, D.C. | | | | | | | | | | JAN 15 1968 | | | | | | | | | | Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | |
|--|---------|------------------|--|---------------------------------|--------|--|------|------------------|---|---|--|------------------------|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 01205 | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| DALE PHILIP KERWOOD | | | | | | | | | Month Day Year
1-12 1968 | | | 9:35 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | |
| M | W | 4-20-42 | | 25 YRS | | MONTHS DAYS | | HOURS MIN. | | Month Day Year
1 12 1968 | | | 9:35 AM | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. COUNTY OF DEATH | | | | | |
| NEW YORK | | | USA | | | NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | MONTGOMERY | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| TAKOMA PARK | | | WASH. SAN E HOSP. | | | COMPUTER PROGRAMMER | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| M.D. | | | PRINCE GEORGE | | | W. HYATSVILLE | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | UNKNOWN | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| PHILIP ALDEN KERWOOD | | | EMMA AGNES NICHOLS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| YES | | | UNKNOWN | | | INFORMATION FROM WALLET | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 484X Acute Bilateral Interstitial | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) Pneumonitis | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 492X | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| CAUSE OF DEATH | | | HOUR A.M. P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | | | | |
| Belden R. Reap | | | M.D. | | | JAN. 12, 1968 | | | | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | | | | | | | | | |
| BELDEN R. REAP, M.D. | | | ADDRESS (Street, City, Town, or County) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Removal | | | 1-16-68 | | | Mount Olivet | | | Denver Colorado | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| W.W. Chambers Inc. | | | 1400 Chapin Street Wash. D.C. 20009 | | | JAN 18 1968 | | | Charles Judge | | | | | |

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2004-01-15 14:00:00

2-2-0-1 W M

ACU MAY 1961

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01208

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01206

| | | | | | | | |
|---|------------------|--|---|---|--------------------------------|---|--|
| 1. DECEASED-NAME
(Type or Print)
First Middle Last
Genevieve Williams Kiley | | | 2a. DATE KNOWN OF DEATH
Month Day Year
1 9 1968 | | | 2b. HOUR
12P.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
2/27/1906 | 6. AGE (In years last birthday)
59 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year
1 9 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
712 E. Notley Rd. | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
Edward Williams | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Frances Rowley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
None | | 17. INFORMANT
Daughter,
Mrs. G.M. Niles | | ADDRESS
Same 712 Notley Rd.
Silver Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary Artery Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | M.D.
22b. DATE SIGNED
JAN. 9, 1968 | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS Street, City, Town, County | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Forest Glen, Maryland | |
| 24. FUNERAL DIRECTOR
Glen Carter C. Reitzel, 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01302

01302

MILITARY SERVICE RECORDS

01302

| | | | | | | | |
|----------------------|--|--------|--|-------------|--|---------------|--|
| NAME | | LAST | | FIRST | | MIDDLE | |
| DATE OF BIRTH | | MONTH | | DAY | | YEAR | |
| PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| MILITARY SERVICE | | BRANCH | | GRADE | | SERIAL NUMBER | |
| DATE OF ENTRY | | MONTH | | DAY | | YEAR | |
| DATE OF DISCHARGE | | MONTH | | DAY | | YEAR | |
| REASON FOR DISCHARGE | | CODE | | DESCRIPTION | | REMARKS | |
| SIGNATURE | | DATE | | PLACE | | OFFICIAL | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-14
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01209 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Twin Baby Boy "A" | | | KING | | | January 1 1968 | | 1012AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Male | | Caucasian | | 31 December 1967 | | YRS. | | 11 7 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Maryland | | USA | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Naval Hospital | | N/A | | N/A | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Prince George Riverdale | | | | | | 4600 Tuckerman Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Unknown | | | Mary King | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | Md. | |
| N/A | | N/A | | Woodrow King, | | 4600 Tuckerman St., | | Riverdale | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>Prematurity</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 7735 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 31</u> , 19 <u>67</u> , to <u>Jan. 1</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Jan. 1</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| <u>Gene P. Swartz</u> | | Jan. 3, 1968 | | Gene P. Swartz, M. D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | 22g. ADDRESS | | | | | |
| Naval Hospital, Bethesda, Md. | | Naval Hospital, Bethesda, Md. | | Naval Hospital, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | 1-5-68 | | Cedar Hill Crematory | | Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 24b. REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | |
| Falls Church Funeral Home | | 1102 West Broad St., Falls Church, Va. | | DATE JAN 8 1968 | | <u>Charles Jones</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (1)
30M REV. 7/68

| 01210 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01208 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | HOURS MIN. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Twin Baby Boy "B" KING | | | | | | | | | | January 1 Day 1968 | | | | | | | | | | 1212 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Male | | | | | | | | | | Caucasian | | | | | | | | | | 31 December 1967 | | | | | | | | | | YRS. | | | | | | | | | | 3 12 | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | | | | | | | Naval Hospital | | | | | | | | | | N/A | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Prince George Riverdale | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4600 Tuckerman Street | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Unknown | | | | | | | | | | Mary | | | | | | | | | | King | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | N/A | | | | | | | | | | Woodrow King, 4600 Tuckerman St., Riverdale/ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 7761 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Prematurity | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7735 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 31, 1967, to Jan. 1, 1968, that (I) (we) last saw the deceased alive on Jan. 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gene P. Swartz, M. D. | | | | | | | | | | 3 Jan. 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gene P. Swartz, M. D. | | | | | | | | | | Naval Hospital, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cremation | | | | | | | | | | 1-5-68 | | | | | | | | | | Cedar Hill Crematory | | | | | | | | | | Washington D. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Falls Church Funeral Home | | | | | | | | | | DATE JAN 8 1968 | | | | | | | | | | J. C. C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1102 West Broad St., Falls Church, Virginia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

24510

0-7-000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|---|--|--|
| 01211 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 02827 | |
| Item 13e Film G397 2/19/68 kk | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
melle King | | | 2a. DATE OF DEATH Month Day Year
1 31 68 | | 2b. HOUR
9-8 M |
| 3. SEX
Female | 4. RACE
Colored | 5. DATE OF BIRTH
Apr. 25, 1885 | | 6. AGE (In years last birthday)
82 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Rockville, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Petomac Valley Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montg. | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
5708 Dimes Road |
| 14. FATHER'S NAME First Middle Last
Henson Dow | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lucinda Clemons | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217-36-8659 | 17. INFORMANT
Lula Ricks 1414 V. St. N.W. 202 Sister Washington D.C. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4330 cerebral infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (c) gen. atherosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hrs 1 wk 10 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
HBP | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1955, to 2/3/68, that (I) (we) lost saw the deceased alive on 1/30/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
George R. Snowden | | 22c. DATE SIGNED
2/3/68 | | 22d. PHYSICIAN'S NAME (Type)
George R. Snowden | |
| 22e. ADDRESS
Rockville, Md. | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Ash Memorial Cem. | |
| 23d. LOCATION (City or Town) (County) (State)
Sandy Spring Montg Md. | | | | | |
| 24. FUNERAL DIRECTOR
George R. Snowden | | 25a. REC'D BY REGISTRAR
FEB 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

01310

STATE OF DEATH

1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01212 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01209 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour Min. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Abe none KRAMER | | | | | | | | | | January 10 1967 | | | | | | | | | | 225 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Male | | | | | | | | | | Caucasian | | | | | | | | | | Dec. 13, 1908 | | | | | | | | | | 59 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ohio | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda, Md. | | | | | | | | | | Naval Hospital | | | | | | | | | | Foreign Service Officer Govt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Montgomery | | | | | | | | | | Rockville | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 10201 Grosvenor Pl. Apt. / 1507 | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jacob Kramer | | | | | | | | | | Celia Katz | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | 1942-47 | | | | | | | | | | Rockville, Md. | | | | | | | | | | Mrs. Alicia G. Kramer, 10201 Grosvenor Pl. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | IMMEDIATE CAUSE (a) Bilateral bronchopneumonia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2041 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Chronic lymphocytic leukemia | | | | | | | | | | | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2040 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from Nov. 28, 1967, to Jan. 10, 1968, that (X) (we) lost saw the deceased alive on Jan. 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles S. Reeves | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 11 January 1967 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles S. Reeves, M. D. | | | | | | | | | | Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 1-14-68 | | | | | | | | | | Garden of Eternity | | | | | | | | | | San Francisco, Calif. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Home | | | | | | | | | | DATE | | | | | | | | | | JAN 15 1968 | | | | | | | | | | f Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7557 Wisconsin Ave., Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

\$1520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-7. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01215

Items 13a, b, c, e

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01210

| | | | | | | | | | |
|--|---------------------|--|---|---|---|--|---|--|---------------------------|
| 1. DECEASED-NAME
(Type or Print) | | | First
<i>PETER</i> | Middle
<i>William</i> | Last
<i>LA CORTE</i> | 2a. DATE KNOWN OF DEATH
Month <i>Jan</i> Day <i>1</i> Year <i>1968</i> | | | 2b. HOUR
<i>3:20</i> M |
| 3. SEX
<i>Male</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
<i>10/20/1917</i> | 6. AGE (in years last birthday)
<i>50</i> YRS | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN _____ | | 2c. DATE PRONOUNCED DEAD
Month <i>Jan</i> Day <i>1</i> Year <i>1968</i> | 2d. HOUR
<i>3:20</i> M |
| 7a. BIRTHPLACE (State or foreign country)
<i>Wash DC</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
- | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD DC</i> | | | 13b. COUNTY
<i>Washington</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>522 22nd St. N.W.</i> | | |
| 14. FATHER'S NAME
First <i>John</i> Middle _____ Last <i>La Corte</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Rose</i> Middle <i>Lo</i> Last <i>medico</i> | | | ADDRESS
<i>2633 Farmington Dr. Alexandria, Virginia</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
<i>Yes</i> | | | 16b. SOCIAL SECURITY NO.
<i>577-03-5268</i> | | 17. INFORMANT (Brother)
<i>William LaCorte</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
412.9 DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cardio Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<i>Jan 1 - 1968</i> | | | |
| EXAMINER'S NAME (Type)
<i>John G. Ball, M.D.</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1/4/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Bladensburg, P.G.Co., Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Joseph Gawler's Sons, Inc., Washington, D. C.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 5 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J Charles Judge</i> | |

01310

01310

RECEIVED BY THE BUREAU OF THE
INTERNAL SECURITY OF THE
UNITED STATES DEPARTMENT OF JUSTICE

100-2511



100-2511
JAN 2 1960
FBI

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|------------------------------------|---|---|--|---------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201 | | | | | | | | | |
| 01214 | | | | | | | | | |
| 01211 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| JOSEPHINE | | | DROUIN | | | LAFORME | | | JANUARY 7 1968 3:45 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. YRS. | |
| Female | | WHITE | | 2-11-88 | | 79 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| SKOWHEGAN MAINE | | | U.S.A. | | | | MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BETHESDA | | | SUBURBAN Hosp. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER RFD#1 SKOWHEGAN MAINE |
| MARYLAND | | | MONTGOMERY | | Rockville | | YES | | 504 CRABB AVE. |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| EPHERIN DROUIN | | | EVELINE FOURNIER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | | | | |
| NO | | | | | CHARLES LAFORME RFD#1 SKOWHEGAN MAINE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5900 Chronic pyelonephritis
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
6000 Arteriosclerotic Cardiovascular Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1967, to 1/1, 1968, that (I) (we) last saw the deceased alive on 12/31, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
L. I. LEAL | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/1/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| L. I. LEAL | | | | | Gaithersburg, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) Som (County) (State) | | | |
| Burial | | 1-5-68 | | Calvary Cemetery | | Skowhegan City, Maine | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | JAN 5 1968 | | Charles Judge | | |

11810

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RECEIVED

11810



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 01215 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01212 | | | | | | | | | | | | | | |
| Item 6 Film G397 2/7/68 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
STEPHEN B. LANE | | | | | | | | | | 2a. DATE OF DEATH
JAN. Month 27 Day Year 68 | | | | | | | | | | 2b. HOUR
4A M | | | | | | | | | | | | | | |
| 3. SEX
M | | | | | 4. RACE
W | | | | | 5. DATE OF BIRTH
12-28-16 | | | | | 6. AGE (In years last birthday)
51 5/4 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
DC | | | | | 7b. CITIZEN OF WHAT COUNTRY?
US | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | | 13b. COUNTY
MONTGOMERY | | | | | 13c. CITY OR TOWN
BETHESDA | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
5815 WALTON RD. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Bertran Lane | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if not unknown) Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO.
216-10-5654 | | | | | 17. INFORMANT Address
Carol Jane Lane 5815 Walton Rd Md Bethesda | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1530 Metastatic Carcinoma of Liver
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Rt. Colon
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs
1 1/2 yrs | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1530 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
July 66 | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Colon | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1966, to Jan 1968, that (I) (we) saw the deceased alive on Jan 26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
James W. Egan DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
1/27/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES W. EGAN | | | | | 22e. ADDRESS
5413 Cedar Lane
Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Type)
Burial | | | | | 23b. DATE
1-31-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Rockville Mont Md | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | | | | ADDRESS
7557 Wisconsin Ave
Bethesda, Md | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 2 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
William Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01216 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01213 | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|------------------------|--|--|--|------------------|--|--|--|----------------------------|--|--|--|------|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | | | 2b. HOUR | | | | | | | | | | | |
| First | | | | Middle | | | | Last | | | | Month | | | | Day | | | | Year | | | | M | | | | | | | | | | | |
| Mary | | | | Alice | | | | LAQUEUR | | | | January | | | | 29 | | | | 1968 | | | | 940A | | | | | | | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | |
| Female | | | | Caucasian | | | | Oct. 8, 1913 | | | | 54 YRS. | | | | MONTHS | | | | DAYS | | | | HOURS | | | | MIN. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| Lakewood, Ohio | | | | USA | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| Bethesda | | | | Naval Hospital | | | | Housewife | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | Montgomery | | | | Chevy Chase | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 5609 Montgomery Street | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First | | | | Middle | | | | Last | | | | First | | | | Middle | | | | Last | | | | | | | | | | | | | | | |
| Harry Murphy | | | | Florence | | | | Walter | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | | | | Md. | | | | | | | | | | | | | | | | | | | |
| No | | | | none | | | | Chevy Chase | | | | Dr. Gert L. Laqueur, 5609 Montgomery St. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Extensive Carcinomatosis</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1830 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Primary carcinoma ovary</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1750 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | yes | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION | | | | Street or R.F.D. No. | | | | City or Town | | | | County | | | | State | | | | | | | | | | | |
| While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 19, 1968, to Jan. 29, 1968, that (X) (we) last saw the deceased alive on Jan. 29, 1968, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | Jan. 30, 1968 | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| Robert L. Gibbs, M. D. | | | | | | | | | | | | Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | |
| Cremation | | | | 1/30/68 | | | | Cedar Hill Crematory | | | | Washington, D. C. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Falls Church Funeral Home | | | | | | | | | | | | DATE FEB 2 1968 | | | | | | | | | | | | | | | | | | | | | | | |
| 7557 Wisconsin Ave., Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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1. The first part of the document is a list of names and dates, arranged in columns. The names are written in a cursive script, and the dates are in a standard font. The list appears to be a record of some kind, possibly a birth or death register.

2. The second part of the document is a large, empty rectangular area, which may be a space for a signature or a stamp.

3. The third part of the document is a list of names and dates, similar to the first part, but with some additional information, possibly a description of the individuals or the events.

4. The fourth part of the document is a large, empty rectangular area, similar to the second part, which may be a space for a signature or a stamp.

5. The fifth part of the document is a list of names and dates, similar to the first and third parts, but with some additional information, possibly a description of the individuals or the events.

6. The sixth part of the document is a large, empty rectangular area, similar to the second and fourth parts, which may be a space for a signature or a stamp.

7. The seventh part of the document is a list of names and dates, similar to the first, third, and fifth parts, but with some additional information, possibly a description of the individuals or the events.

8. The eighth part of the document is a large, empty rectangular area, similar to the second, fourth, and sixth parts, which may be a space for a signature or a stamp.

9. The ninth part of the document is a list of names and dates, similar to the first, third, fifth, and seventh parts, but with some additional information, possibly a description of the individuals or the events.

10. The tenth part of the document is a large, empty rectangular area, similar to the second, fourth, sixth, and eighth parts, which may be a space for a signature or a stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Roberts E Latimer | | | | | | 2a. DATE OF DEATH Month Day Year
1 31 1968 | | | 2b. HOUR MIN.
6 30 A | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
4-11-1886 | | | 6. AGE (In years lost birthday)
81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Atlee Woodland Nursing Home - 1000 Daleview Dr. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Excavation Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Self employed | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Washington, D.C. | | | 13b. COUNTY
D.C. | | 13c. CITY OR TOWN
Wash., D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1303 Floral Street | | | |
| 14. FATHER'S NAME First Middle Last
William J. Latimer | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Bessant | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
ues | | 17. INFORMANT Address
Mrs Jay M. Mount, 7408 Wyndale Rd., Ch Ch, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis with
4129
DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201
(b) Coronary Thrombosis (old)
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral Thrombosis (old) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
3 years
3 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Generalized Arterio-sclerosis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 1965 to Jan 31, 1968 , that (I) (we) lost saw the deceased alive on Jan 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
George L Ball | | | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS.
<input type="checkbox"/> | | 22c. DATE SIGNED
Jan 31, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
George L Ball | | | | 22e. ADDRESS
10620 Georgia Ave Silver Spring, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Feb. 3, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges County, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Glen Carter | | | | ADDRESS
8434 Georgia Ave. | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |
| VR A15 (4)
30M REV. 1/68 | | | | Warner C. Humphrey, Inc. Silver Spring, Md. | | 5 1968 | | | | | | |

01211

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4-11-1941

White

White

Montgomery

4215

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Washington, D.C.

1307 Federal Street

President

Major

Dr. Latimer

William

NO

Mr. J. M. Hunt, West Virginia, C. O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 1-68

| M | | | | | | | | | | | |
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| 01215 | | | | | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01215 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Eva M. [unclear] Bridge Lawrence</i> | | | 2a. DATE OF DEATH
Month <i>1</i> Day <i>1</i> Year <i>68</i> | | | 2b. HOUR
<i>3:50</i> AM | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>August 6, 1885</i> | | 6. AGE (In years last birthday)
<i>82</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>New Hampshire</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Olney, Md.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Brooke Grove Foundation</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>17214 Emerson Drive</i> | | | |
| 14. FATHER'S NAME First <i>Horace</i> Middle <i>H.</i> Last <i>Bridge</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Chloe</i> Middle <i></i> Last <i>Dunn</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>012-28-7043D</i> | | 17. INFORMANT
<i>Mrs. Thomas K. Wilkinson</i> Address <i>17214 Emerson Drive Silver Spring, Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i>
<i>4120</i> DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>443X</i>
(b) <i>CEREBRAL ARTERIOSCLEROSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>ARTERIOSCLEROTIC, HYPERTENSIVE C.V.D.s</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 DAYS</i>
<i>YES</i>
<i>YES</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>HYPOSTATIC PNEUMONIA - PULMONARY CONGESTION.</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>
P.M. <i></i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>OCTOBER, 1964</i> , to <i>Jan 1, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-31-1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Donald E. Lewis MD</i> | | | | | 22c. DATE SIGNED
<i>1/1/68</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Donald R. Lewis</i> | | | | | 22e. ADDRESS
<i>700 Cloverly St. Silver Spring, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>Jan. 4, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodland Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Keene, New Hampshire</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | | | 25a. REC'D BY REGISTRAR
<i>JAN 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | | |

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WATER RESOURCES DIVISION

REPORT OF INVESTIGATION

NO. 1

WATER RESOURCES DIVISION

REPORT OF INVESTIGATION

NO. 1

WATER RESOURCES DIVISION

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WATER RESOURCES DIVISION

REPORT OF INVESTIGATION

NO. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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|---|--|--|--|--|--|
| 01219 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01216 | |
| 1. DECEASED-NAME (Type or print)
First Middle Last
<i>ALMA GRACE Lind</i> | | | | 2a. DATE OF DEATH
Month Day Year
<i>1 24 68</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>Nov. 18, 1884</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Iowa</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 6. AGE (In years last birthday)
<i>83</i> YRS. | |
| 10. CITY OR TOWN OF DEATH
<i>5. Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Althea Woodland Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>teacher SUPERVISOR</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>District of Columbia</i> | | 13b. COUNTY
<i>None</i> | | 13c. CITY OR TOWN
<i>Washington</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>Andrew K. Lind</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Rinnie Hanks Lind</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes () or unknown () | | 16b. SOCIAL SECURITY NO.
<i>579604033</i> | | 17. INFORMANT
Address
<i>Mrs. Robert E. Dudley 5546 N. 325th, Oak, Va.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Renal Insufficiency</i>
<i>4409</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Arteriosclerotic Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>72 hrs</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4500 Parkinsonism</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES () NO () | |
| 21a. ACCIDENT WAS UNDERLYING
(If either, notify medical examiner)
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>67</i> , to <i>Jan</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-23</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Bernard A. Fitzgerald M.D.</i> | | | | 22c. DATE SIGNED
<i>1-24-68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>BERNARD A. FITZGERALD</i> | | | | 22e. ADDRESS
<i>217 UNIV. BLVD. E. SILVER SPRING, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | 23b. DATE
<i>1-25-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Crematory</i> | |
| 24. FUNERAL DIRECTOR
<i>Gawlers</i> | | ADDRESS
<i>5130 Wise Ave. Wash. D.C.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Suitland, Md.</i> | |
| 25a. REC'D BY REGISTRAR
DATE <i>JAN 31 1968</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|-------------------------------|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|
| 01220 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01217 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
LOUISE MARY LINKINS | | | | | | | | | | | | 2a. DATE OF DEATH
1 Month 3 Day 18 Year | | | | | | | | | | | | 2b. HOUR
8:30 A M | | | | | | | | | | | |
| 3. SEX
FEMALE | | | | 4. RACE
CAUS | | | | 5. DATE OF BIRTH
1890 | | | | 6. AGE (In years last birthday)
78 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
ENGLAND | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
UNIVERSITY NURSING HOME | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEMAKER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | 13b. COUNTY
MONTGOMERY | | | | 13c. CITY OR TOWN
S.S. | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
1400 FENWICK LANE | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
LOWRY | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
NUT AVAILABLE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16b. SOCIAL SECURITY NO.
578-03-1029 | | | | 17. INFORMANT Address
FRANCIS J. LINKINS, 1400 FENWICK LANE SSMd | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
436.0
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension (arteriosclerotic)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerosis</u>
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 weeks
years
years | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Psychoneurotic - Senility</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1968, to Jan 3, 1968, that (I) (we) last saw the deceased alive on Jan 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Philip E. Jones M.D. DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)
Philip E. Jones, M.D.
22e. ADDRESS
800 Pershing Drive
Silver Spring Md 20910 | | | | | | | | | | | | 22c. DATE SIGNED
1-3-68 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE
Jan 8, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Arthur Walters, 254 Carroll St. NW-Wash. 40 C | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 8 1968
25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|----------------------------------|---|---|---|---|--|---|---|--|
| 01221 | | | | | | | | | |
| 01215 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8504 LEONARD DRIVE | | | | | d. STREET ADDRESS
8504 LEONARD DRIVE | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROSETTA Middle Last LISSAUER | | | 4. DATE OF DEATH
Month JANUARY Day 22 Year 1968 | | | | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 14, 1911 | | 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACOB HOROWITZ | | | | | 14. MOTHER'S MAIDEN NAME
MARY KLEINMAN | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | 16. SOCIAL SECURITY NO.
412-36-6370 | | 17. INFORMANT
MR. LESLIE LISSAUER, 8504 LEONARD DRIVE | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, metastatic
1830
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO Carcinoma of ovary
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
1750 | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 mo
8 mo. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to Jan. 22 , 19 68 , that (I) (we) last saw the deceased alive on Jan. 14 , 19 68 , and that death occurred at 1 P. M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Jos. Berkenbilt | | | | | 22b. DATE SIGNED
Jan. 22, 1968 | | 22c. PHYSICIAN'S NAME (Type)
DR. JOSEPH BERKENBILT | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | 23b. DATE THEREOF
1-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE HEBREW | | 23d. LOCATION (City, town or county) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | 25a. REC'D BY REGISTRAR
JAN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

01551

01551

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JAN 11 1968
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum format with fields for TO, FROM, SUBJECT, and a body of text.]

JAN 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|--|---|---|
| 012122 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01219 | |
| Item#13Film#G397 2/16/68 ph | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME
(Type or print) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| First Middle Last
Carl August Loeffler | | | Month Day Year
Jan. 30, 1968 | | 10⁰⁵ M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| Male | White | January 12, 1873 | | 95 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| Wash., D.C. | United States | Montgomery County Md. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda, Md. | Westwood Nursing Home | Sec. of U.S. Senate | | Retired | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| D.C. | Montgomery | Washington | | 4615 29th Pl., N.W. | |
| Maryland | | Bethesda | | 5101 Ridgely Rd | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| Charles David Adam Loeffler | | | Louisa Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | | |
| unknown | | 579-60-0109 | Mrs. H. R. Josephson 5504 Burling Ct. Beth. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | 3 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis | | | | | 5 years |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerosis & Hypertension | | | | | 24 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 332x | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1943 to Jan 30, 1968 , that (I) (we) last saw the deceased alive on Jan 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Neil P. Campbell DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/30/68 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Neil Campbell | | | | 22e. ADDRESS 1629 Colorado Road, Washington, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2-1-1968 | | Rock Creek Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | | | |
| Washington, D.C. | | DATE FEB 5 1968 | | | |
| 24. FUNERAL DIRECTOR ADDRESS Joseph Gwili's Son, Inc., Wash., D.C. | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Fig. 5.

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Calligraphic style

1. *Figure 1*

1176

no. 10.

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2010-01-27

1899 Colorado Coal, Washington - D.C.

1997-1998

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01223

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01220

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Sara C</i> First Middle Last <i>Herilliere</i> | | | 2a. DATE OF DEATH
Month <i>January</i> Day <i>18</i> Year <i>68</i> | | 2b. HOUR <i>4:10</i> P.M. |
| 3. SEX <i>Female</i> | 4. RACE <i>white</i> | 5. DATE OF BIRTH <i>9/11/88</i> | 6. AGE (in years lost birthday) <i>79</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <i>Mississippi</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | 13b. COUNTY <i>Montgomery</i> | 13c. CITY OR TOWN <i>Bethesda</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <i>4703 Highland Ave</i> | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>Campbell</i> Last <i>Unknown</i> | 15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give dates of service) | 16b. SOCIAL SECURITY NO. <i>2509</i> | 17. INFORMANT <i>Miss S. Behar - 226 East 6th St - Nevada</i> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>bronchopneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>diabetes</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>260x generalized arteriosclerosis</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i>
<i>20 yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>260x generalized arteriosclerosis</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-56</i> , 19 <i>68</i> , to <i>12-19-68</i> , that (I) (we) lost saw the deceased alive on <i>12-19-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>John M. Wyman</i> | DEGREE <i>MD</i> | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED <i>1/19/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>JOHN M. WYMAN</i> | 22e. ADDRESS <i>7801 WOLFENBARGER AVE BETHESDA, MD.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | 23b. DATE <i>1-20-68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i> | 23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i> | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Md.</i> | | 25a. REC'D BY REGISTRAR DATE <i>JAN 26 1968</i> | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

01330

CENTRAL OF GEORGIA

01330

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01221

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | |
|--|-------------------------------|--|--|--|
| 1. DECEASED NAME (Type or Print)
First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Luck</u> | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Month <u>Jan</u> Day <u>13</u> Year <u>1968</u> | | 2b. HOUR
<u>10:30</u> A.M. |
| 3. SEX
<u>Fe.</u> | 4. RACE
<u>W.</u> | 5. DATE OF BIRTH
<u>Aug-26-1901</u> | 6. AGE (In years lost birthday)
<u>66</u> YRS. | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> |
| 7a. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<u>Montgomery</u> Md. |
| 10. CITY OR TOWN OF DEATH
<u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>5062 Park Place</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u> </u> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> | | 13b. COUNTY
<u>Montgomery</u> | 13c. CITY OR TOWN
<u>Bethesda</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First <u>George</u> Middle <u>Henry</u> Last <u>Bell</u> | | 15. MOTHER'S MAIDEN NAME First <u>Blanche</u> Middle <u> </u> Last <u>Creamer</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | 16b. SOCIAL SECURITY NO.
<u>578-62-9393</u> | | 17. INFORMANT
<u>Bertha Wise-Sister-See Item 13.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, acute</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u> </u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause
<u>lost 490X</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Rheumatoid arthritis</u> | | | | |
| 19a. DATE OF OPERATION
<u> </u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
<u> </u> | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u> </u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u> </u> |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u> </u> | | 21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u> |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
<u>John B. Bell</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
<u>1/14/68</u> |
| EXAMINER'S NAME (Type)
<u> </u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county)
<u> </u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE
<u>1-16-1968</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges C. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc.</u> | | ADDRESS
<u>5130 Wise Ave. N.W.</u>
<u>Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>JAN 18 1968</u> |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

01331

RECEIVED

01331



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 01222 | |
|---|------------------|--|--|--|--|---|---|--|------------------------|---|------------------------|
| 1. DECEASED-NAME (Type or Print) MAGID ABRAHAM NONE | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 27 Year 1968 | 2b. HOUR 7:30 M |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 8-25-86 | 6. AGE (In years last birthday) 81 YRS. | IF UNDER 1 YEAR MONTHS | OAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month 1 Day 29 Year 1968 | 2d. HOUR 7:30 M | | |
| 7a. BIRTHPLACE (State or foreign country) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? AMER | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH TALOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N. Y. | | | 13b. COUNTY BROOKLYN | | 13c. CITY OR TOWN BROOKLYN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 34 MINTWOOD ST. | | | | |
| 14. FATHER'S NAME First Unknown Middle Unknown Last Unknown | | | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital RECORD ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED JAN. 27, 1968 | | | | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE JAN-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY BETH MOSES CEM | | 23d. LOCATION (City or Town) PINEAUX-L.I. N.Y. | | County | | State | |
| 24. FUNERAL DIRECTOR B. Danyansky & Sons | | | | ADDRESS 3501-14th NW | | 25a. REC'D BY REGISTRAR JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

02570

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|--|---|--------------------------------------|
| 01226 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | |
| CERTIFICATE OF DEATH | | | |
| 01223 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington D.C.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home</u> | | d. STREET ADDRESS
<u>169 U St. N.E.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Emma Forbes Magruder</u> | | 4. DATE OF DEATH
Month <u>Jan.</u> Day <u>23</u> Year <u>1968</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>81</u> yrs. |
| 9. AGE (In years last birthday)
<u>81</u> yrs. | | IF UNDER 1 YEAR
Months <u>23</u> Days <u>19</u> Hours <u>68</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>UNK</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNK</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>HERBERT MAGRUDER</u> | | 518 ^{Address} TUCKERMAN ST., WASHINGTON, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>437.9</u> IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u></u>
DUE TO
(c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>334X</u> <u>Broncho pneumonia</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/20, 1967</u> , to <u>1/23, 1968</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that death occurred at <u></u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Myron L. Hendon</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Myron L. Hendon</u> | | 22d. ADDRESS
<u>2309 Sharpsfield Rd. N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>1/26/68</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>MT. OLIVET CEM.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>WASHINGTON, D.C.</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert E. Miller</u> | | 25a. REC'D BY REGISTRAR
<u>JAN 26 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print)
William Ray Mahaffey | | | | | | 2a. DATE OF DEATH
Month January Day 10 Year 1968 | | | 2b. HOUR 4:00 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
March 7, 1963 | | 6. AGE (In years lost birthday)
4 YRS. | | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
-- | | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
West Virginia | | 13b. COUNTY
Raleigh | | 13c. CITY OR TOWN
Beckley | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
205 Earhart Street | | | |
| 14. FATHER'S NAME First William Middle E. Last Mahaffey | | | | 15. MOTHER'S MAIDEN NAME First Lois Middle Kathryn Last Powledge | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, Bethesda, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gram-negative septicemia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Wiskott-Aldrich Syndrome | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Paralysis due to subdural hematoma. (1-1/2 years) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 21, 1966 , to January 10, 1968 , that (X) (we) lost saw the deceased alive on January 10, 1968 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas Waldmann MD DEGREE | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10 January 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas Waldmann, MD | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
1/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Falls Church F. H., Falls Church, Va. | | 23d. LOCATION (City or Town) (County) (State)
Hampton, Virginia | | | | | |
| 24. FUNERAL DIRECTOR
Falls Church F. H., Falls Church, Va. | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
J. J. Judge | | | |

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TABLE 1. (continued)

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4. *Journal of the American Medical Association* 277:1033-1034, 1997

THE LITERARY CENTER

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

The Clinical Center, NIH

Form - 097-116

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01228 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01225 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First
ANNA | | | | | | | | | | Middle
MALINASH | | | | | | | | | | Last
MALINASH | | | | | | | | | | Jan
Month
20
Day
1968
Year | | | | | | | | | | 3:15
M | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
White | | | | | | | | | | 5. DATE OF BIRTH
February 12, 1898 | | | | | | | | | | 6. AGE (In years last birthday)
69 YRS. | | | | | | | | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | | | | | | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Poland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bethesda-Sil Spg Nurs.Home | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
----- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | | | | | | 13b. COUNTY
Montg. | | | | | | | | | | 13c. CITY OR TOWN
SSpg. | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
816 Easley Street | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First
Wolfe | | | | | | | | | | Middle
Gumovitz | | | | | | | | | | Last
Wolfe | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First
unknown | | | | | | | | | | Middle
unknown | | | | | | | | | | Last
unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | | | | | | | | (If yes give war or dates of service)
----- | | | | | | | | | | 16b. SOCIAL SECURITY NO.
050-22-7656 | | | | | | | | | | 17. INFORMANT
Pearl Hanin, 6223 Goodview St., Bethesda, Md | | | | | | | | | | Address
Bethesda, Md | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia
2041
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yrs | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
2040 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 20, 1967 , to Jan 20, 1968 , that (I) (we) last saw the deceased alive on 1-13-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Isidore Shulman M.D. | | | | | | | | | | DEGREE
M.D. | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
1-20-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ISIDORE SHULMAN | | | | | | | | | | 22e. ADDRESS
915-19th St. N.W. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
Jan 21, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Nat'l. Memorial Park | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Falls Church, Va. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Goldberg Funeral Home | | | | | | | | | | ADDRESS
4217 9th Street N.W. | | | | | | | | | | 25a. REG. DAY REGISTRAR
JAN 23 1968 | | | | | | | | | | REGISTRAR'S SIGNATURE
J. J. Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | |
|--|-------------------------------------|--|--|--|---|
| 01229 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01226 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Colonial Villa Nursing Home | | | d. STREET ADDRESS
6523 Medwick Drive | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
Annie Mae Manuel | | | 4. DATE OF DEATH
Month Jan Day 25 Year 1968 | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10--17--1892 | | 9. AGE (In years last birthday) yrs. 75 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Government Worker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Morrisville, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
US | | | | | |
| 13. FATHER'S NAME
Lucian Manuel | | | 14. MOTHER'S MAIDEN NAME
Mary | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-46-0754 | | 17. INFORMANT
Nursing Home Records
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X
(b) Arteriosclerosis
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 wks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Bronchopneumonia | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
Not | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 12, 1967 , to Jan 25, 1968 , that (I) (we) lost saw the deceased alive on Jan 24, 1968 , and that death occurred at 6:30 PM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
William F. Simpson, MD | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
1/25/68 | |
| 22c. PHYSICIAN'S NAME (Type)
William F. Simpson, MD | | 22d. ADDRESS
6216 N.H. Ave NE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
1/28/68 | 23c. NAME OF CEMETERY OR CREMATORY
Morrisville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Morrisville, Va. | |
| 24. FUNERAL DIRECTOR The S.H. Hines Company
2901 14th St. N.W. Washington, D.C. | | | 25a. REC'D BY REGISTRAR
DATE JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

ESS 18

doi:10.1017/S0007122615000052

Figure 1. The effect of the concentration of the inhibitor on the rate of polymerization.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Hattie Lucille Marceron | | | 2a. DATE OF DEATH
Month Day Year
January 1, 1968 | | | 2b. HOUR
P
4:55 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
June 23, 1906 | | 6. AGE (In years last birthday)
61 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Colonial Villa Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Washington, D.C. | | 13b. COUNTY
Wash. D.C. | | 13c. CITY OR TOWN
Wash. D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
62 Allison St., N.E. | | 14. FATHER'S NAME First Middle Last
Harry King | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nona Watkins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Marvin F. Marceron, 9903 Julliard Dr. Bethesda, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY + CEREBRAL METASTASES
174X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BREAST + COLON
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
1992 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-27 , 19 67 , to 1-1 , 19 68 , that (I) (we) last saw the deceased alive on 12-28 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Benne G. Bendler | | M.D. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-2-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Benne G. Bendler, M.D. | | 22e. ADDRESS
10820 Ga. Ave. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Salem Meth. | | 23d. LOCATION (City or Town) (County) (State)
Cedar Grove, Md. | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|
| 01231 | | | | | 01228 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| First Middle Last
LAURA D. MARDEN | | | | | Month Day Year
1 14 68 | | | A. M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
12/31/74 | | 6. AGE (In years
last birthday)
93 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
En Route | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
enroute Montgomery General | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
own home | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt. #1 Robin Court, Gaithers | |
| 14. FATHER'S NAME
First Middle Last
John Marlow | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Martha (unknown) X | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
yes | | 17. INFORMANT
Address
Elizabeth Whalen Rt. #1 Robin Court, Gaithers | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/10/68 to 1/14/68, that (I) (we) last
saw the deceased alive on 12/28/67, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James P. Kerr | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/14/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
James P. Kerr, M. D. | | | | 22e. ADDRESS
26618 Ridge Road
Damascus, Maryland | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
Jan. 17, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington | | 23d. LOCATION (City or Town) (County) (State)
Hyattsville, XXXXXXXX Md. | | | |
| 24. FUNERAL DIRECTOR
Glen Carter
Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01521

01521

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

TO: THE ADJUTANT GENERAL
FROM: THE ADJUTANT GENERAL
SUBJECT: THE ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print)
First THOMAS Middle HENRY Last MARTIN | | | | | 2a. DATE OF DEATH
Jan. Month I Day 4 Year 68 | | | 2b. HOUR
4:00 P. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
9/17/82 | | 6. AGE (In years last birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____
IF UNDER 24 HRS.
HOURS _____ MIN _____ | | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
SilverSprg | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4708 Ednor Road | |
| 14. FATHER'S NAME First Thomas Middle _____ Last Martin | | | 15. MOTHER'S MAIDEN NAME First Mary Middle _____ Last Story | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
220-44-4207 | | 17. INFORMANT Address
Medical Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia edema</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hr
4 days
15 yrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year _____
P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work _____ | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Jan</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>A. Dement Bonifant</u> DEGREE _____ | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan. 5 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) A. Dement Bonifant, M.D. | | | | | 22e. ADDRESS
Medical Center, Sandy Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 6 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville | | 23d. LOCATION (City or Town) (County) (State)
Rockville Mont. Md | | | | |
| 24. FUNERAL DIRECTOR
Francis H. Barber ADDRESS
Laytonsville Md | | | | | 25a. REC'D BY REGISTRAR
JAN 10 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Francis H. Barber</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67 jwb

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|--|--|--|--|--|---|---|---|
| 01233 | | | | 01230 | | | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. LENGTH OF STAY IN INSTITUTION
<u>June 12 1967</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>College Park</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Randolph Hills Nursing Home</u> | | | | d. STREET ADDRESS
<u>8803 48th Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>James W Maxwell</u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>11</u> Year <u>1968</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 20, 1884</u> | | 9. AGE (In years last birthday)
<u>83</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>11</u> Days <u>19</u> Hours <u>68</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Foreman - Cold Storage Warehouse (Food)</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Food</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Texas</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>James F. Maxwell</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret E. Goldston</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>578-03-05007</u> | | 17. INFORMANT
Annie V. Maxwell Same as # 2 (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Viral Pneumonia</u>
DUE TO <u>Probable Influenza</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>480x</u>
(b) <u>Probable Influenza</u>
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 WK</u>
<u>3 WKS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Generalized ARTERIOSCLEROSIS, Advanced OSTEOARTHRITIS</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>67</u> , to <u>1/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> , 19 <u>68</u> , and that death occurred at <u>11:30</u> AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>R.T. Benack MD</u> | | | | 22b. DATE SIGNED
<u>1/11/68</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>R.T. BENACK MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>1/15/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Geo. W. Wash. Ceme.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Hyattsville, Md., 20783</u> | |
| 24. FUNERAL DIRECTOR
<u>Francis Gasch's Sons</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 16 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01530

01530

at 1000 ft

3

(see) 03.00.00 01.00.00

01.00.00 01.00.00

01.00.00 01.00.00

01.00.00 01.00.00 01.00.00 01.00.00

01.00.00 01.00.00 01.00.00 01.00.00

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01234

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01231

| | | | | | | | | | |
|--|---------------------|--|--|---|---|--|--|--|----------------------|
| 1. DECEASED-NAME
(Type or Print) James R. MC CABE | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 15 Year 1968 | | | 2b. AMR 125M | | | |
| 3. SEX Male | 4. RACE Cauc | 5. DATE OF BIRTH Nov. 28, 1928 | 6. AGE (In years last birthday) 39 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Jan. Day 15 Year 1968 | | | 2d. HOUR 125M |
| 7a. BIRTHPLACE (State or foreign country) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | | Md. |
| 10. CITY OR TOWN OF DEATH Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Captain Air Force | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware | | | 13b. COUNTY Dover | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER U.S. Air Force Base | | |
| 14. FATHER'S NAME First James Middle R. Last MC CABE | | | 15. MOTHER'S MAIDEN NAME First Ida | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Navy/Air Force Records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Epidural, Subarachnoid & Intracerebral
887X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hemorrhage -
DUE TO, OR AS A CONSEQUENCE OF
Trauma from Fall
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 5 days - | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
904.7 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year 3:30 P.M. Jan 10 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fall during epileptic like seizure | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital | | 21f. LOCATION Street or R.F.D. No. U.S. Air Force Base - Dover | | City or Town Dover County Delaware State Delaware | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Jan. 15, 1968 | | | |
| EXAMINER'S NAME (Type) John G. Ball, M. D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Rem. | | 23b. DATE 1/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Falls Church Funeral Home | | | 23d. LOCATION (City or Town) (County) (State) Boise City, OKLA. | | |
| 24. FUNERAL DIRECTOR Falls Church Funeral Home | | | | 25a. REC'D BY REGISTRAR R. P. Poterfield | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| 1102 West Broad Street, Falls Church, Virginia | | | | DATE JAN 18 1968 | | | | | |

DESIG

Box 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01232 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print)
Henry Paul McCoy | | | | | 2a. DATE OF DEATH
Month January Day 10 Year 1968 | | | 2b. HOUR
12:40 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
25 July 1915 | | 6. AGE (In years last birthday)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Florida | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Orlando | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1808 Culver Road | |
| 14. FATHER'S NAME First Middle Last
Harlow W. McCoy | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mousie Annie Fraley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
The Medical Record Address
The Clinical Center, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
3960
DUE TO, OR AS A CONSEQUENCE OF
replacement
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Status postoperative aortic and mitral valve/
DUE TO, OR AS A CONSEQUENCE OF
(c) Rheumatic Heart Disease
6 days
6 days
years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
40X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that xx (this hospital) attended the deceased from Dec. 10 , 19 67 , to Jan. 10 , 19 68 , that (1) (we) last saw the deceased alive on January 10 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above xx (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Lynn M. Peterson
DEGREE
Lynn M. Peterson, M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10 January 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Lynn M. Peterson, M.D. | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
1-15-1968 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
ORLANDO FLA | | | |
| 24. FUNERAL DIRECTOR
W.W. Chambers
ADDRESS
1400 Chapin Street, Waco, Tex. | | | | | 25a. REC'D BY REGISTRAR
JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

OTHER

REMARKS OR DATA

01234

January 10, 1962

22 July 1962

USA

Contractor

1208 Colver Road

Chicago

1208 Colver Road

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

Chicago

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last
Susan MARY MCCULLAGH | | | 2a. DATE OF DEATH
Month Day Year
January 14 1968 | | 2b. HOUR
0630 | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
May 24, 1965 | | 6. AGE (In years last birthday)
2 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Bethesda | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5002 Cushing Drive | |
| 14. FATHER'S NAME First Middle Last
Robert F. MCCULLAGH | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Catherine Regina MCKENNA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, name of (unknown) N/A (If yes, give war or dates of service) N/A | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT Kensington Address Maryland
Lt. Robert F. McCullagh, 5002 Cushing Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ketoacidosis</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Diabetic Mellitus</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
260x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 12, 1968, to Jan. 14, 1968, that (X) (we) lost the deceased alive on Jan. 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Franklin X. Loeb</i>
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
Jan. 15, 1967 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Franklin X. Loeb, M. D. | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler 1331 Rock Pike
Rockville, Maryland | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>John J. Jones</i> | |

MEDICAL CERTIFICATION

01330

RECEIVED - AIR MAIL - 1944

01330

RECEIVED - AIR MAIL - 1944

TO: [illegible] FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

REMARKS: [illegible]

INITIALS: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

BRANCH: [illegible]

SECTION: [illegible]

DIVISION: [illegible]

DEPARTMENT: [illegible]

MINISTRY: [illegible]

GOVERNMENT: [illegible]

NATIONALITY: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

INITIALS: [illegible]

01237

CERTIFICATE OF DEATH

01234

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
Harry Thomas McDonald | | | 2a. DATE OF DEATH
Month Day Year
January 24 1968 | | | 2b. HOUR
PM
10:20 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 23, 1933 | | 6. AGE (In years last birthday)
34 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Electrical Lineman | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrical | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
New Jersey | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Phillipsburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
323 Ann Street | |
| 14. FATHER'S NAME
Harry McDonald | | | 15. MOTHER'S MAIDEN NAME
Marie Wieghorst | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
1952-1956 | | 17. INFORMANT
The Medical Record Address | | The Clinical Center, Bethesda, Md. 20014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Choriocarcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
<u>178X</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 Weeks
1 Year | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>November 6, 1967</u> , to <u>January 24, 1968</u> , that (1) (we) lost the deceased alive on <u>January 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert A. Ralph</u> | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>25 January 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert A. Ralph, MD. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
<u>1/29/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Phillip & St. James</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Phillipsburg, N. J.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>James S. Bruzdinski</u> | | | | 25a. REC'D BY REGISTRAR
DATE
<u>JAN 29 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

01235

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Mary Virginia McGarity</i> | | | 2a. DATE OF DEATH
<i>January</i> Month <i>2</i> Day <i>1968</i> Year | | | 2b. HOUR
<i>11 A</i> M | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Dec. 13, 1892</i> | | 6. AGE (In years lost birthday)
<i>75</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Holy Cross</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>109 Williamsburg Dr.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Hiram Howard Moore</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Sadie M. Carothers</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <i>No</i> (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
<i>579-44-0045B</i> | | | 17. INFORMANT Address
<i>Ralph H. McGarity 109 Williamsburg Drive</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction acute</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4201</i>
(b) <i>ASCVD</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized Aging process</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 days</i>
<i>unknown</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Renal shutdown</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 28, 1967</i> to <i>Jan 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 1, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Russell C. Bufalino MD</i> | | 22c. DATE SIGNED
<i>Jan 3, 1968</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Russell C. Bufalino</i> | | 22e. ADDRESS
<i>1429 University Blvd. W. Silver Spg. Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1/4/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Suitland Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
<i>John B. Thomas Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.</i> | | 25a. REC'D BY REGISTRAR
<i>Charles J. Jones</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> | | DATE <i>JAN 8 1968</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|---|---|---|---|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Anne Teresa Meloy | | | | | | 2a. DATE OF DEATH
Month 1 - Day 8 - Year 1968 | | | 2b. HOUR
5:05 P M | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
10/6/1986 1886 | | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3622 Raymond St. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3622 Raymond Street | | | |
| 14. FATHER'S NAME First Middle Last
Daniel Connor | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Brigid McCarthy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
220-50-5431 | | 17. INFORMANT Address
Francis E. Meloy same as above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
433.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis with hypertension, severe
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month.
13 yrs | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-13, 1957 , to 1-8, 1968 , that (I) (we) saw the deceased alive on 1-8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Thomas A. Wildman, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
1-8-68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas A. Wildman | | | | | | 22e. ADDRESS
2032-16th. street, N.W. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | | | | |
| 24. FUNERAL DIRECTOR
The S.H. Hines Co. Washington, D. C. | | | | | | 25a. REC'D BY REGISTRAR
JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

FORM 10-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER DR. REAGS

MEDICAL CERTIFICATION

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING
c. LENGTH OF STAY IN 1b
15-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROCKVILLE
d. STREET ADDRESS
4312 FRANKFORT DRIVE
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
ANDREW LYN MENDELSON | | 4. DATE OF DEATH
Month Day Year
January 11 1968 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 30, 1967 |
| 9. AGE (In years lost birthday) yrs.
3 | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
3 12 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MINOR | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ALLAN L. MENDELSON | | 14. MOTHER'S MAIDEN NAME
ADRIENNE CREED | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
MOTHER | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchitis, viral
466 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
17 hours | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
501 X | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-10 , 19 68 , to 1-11 , 19 68 , that (I) (we) lost saw the deceased alive on 1-10 19 68 , and that death occurred at 7²⁴a.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Melwyn Shapiro | | 22b. DATE SIGNED
1-11-68 | |
| 22c. PHYSICIAN'S NAME (Type)
MELWYN SHAPIRO | | 22d. ADDRESS
1040 UNIVERSITY BLVD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
1/12/68 | 23c. NAME OF CEMETERY OR CREMATORY
King David Memorial Garden Falls Church Va. | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
Donald M. Stein | | 25a. REC'D BY REGISTRAR
232 Carroll | |
| 25b. REGISTRAR'S SIGNATURE
Hebrew Memorial Funeral Home Wash., D. C. | | 25c. DATE
JAN 15 1968 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01241 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01238 | | | |
|--|--|---|--|---|-----------------------|---|------------|--|--|
| 1. DECEASED NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| First MIDDLE Last
LOLA A MERCIER | | | | | Month 1 Day 8 Year 68 | | 10:30 P.M. | | |
| 3. SEX
F | | 4. RACE
Cauc | | 5. DATE OF BIRTH
5/24/92 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
BETHEDA SILVER SPRING NEAR HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SCHOOL TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
CHEVY CHASE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3202 TURNER LANE | |
| 14. FATHER'S NAME First MIDDLE Last
CHARLES L MERCIER | | 15. MOTHER'S MAIDEN NAME First MIDDLE Last
ALICE E. FRICKER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
HIS CHART | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>471X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>480X</u>
(b) <u>flu syndrome</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>2 weeks</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>ASHD, CEREBRAL ARTERIO SCLEROSIS, OSTEOPOROSIS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>67</u> , to <u>1/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John J. Lynch M.D.</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/9/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN J. LYNCH | | 22e. ADDRESS
<u>1234-19th ST NW. WASH D.C.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
<u>JAN. 11, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ROCK CREEK CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>WASHINGTON D.C.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>William M. Hyson</u> | | ADDRESS
<u>HYSON FUNERAL HOME-1300-N ST. N.W. WASH-DC</u> | | 25a. REC'D BY REGISTRAR
<u>JAN 10 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Jones</u> | | | |

1951

1951

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THE", "AND", "OF" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 01242 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01239 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Mikalaski, Dorothy Gertrude | | | 2a. DATE OF DEATH
Month Day Year
1-18-68 | | | 2b. HOUR
9:50 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
11-8-96 | | 6. AGE (In years last birthday)
71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
Amer. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Co. Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. Sanitarium & Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Prince Geo. Co. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
John Erdmann | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Minerva Schools | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
No | | | |
| 16b. SOCIAL SECURITY NO.
579 16 6268-B | | 17. INFORMANT
Dwan Mikalaski - #13-A.B.Y.C. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
Gangrene @ Foot - Amputation @ Leg (AK) | | | | | | | |
| 19a. DATE OF OPERATION
1/15/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gangrene @ Foot | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes. | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 of Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1968, to Jan 18, 1968, that (I) (we) lost saw the deceased alive on Jan 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Boris Rabkin | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 18, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Boris Rabkin | | | | 22e. ADDRESS
1019 University Blvd. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
January 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Prince George's Md. | |
| 24. FUNERAL DIRECTOR
F. Gaschs Sons | | | | ADDRESS
4739 Baltimore Ave. Hyattsville Md. | | 25a. REG. BY REGISTRAR
24 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Judge | | | | | | | |

CESTO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|--|--|--|
| 01243 | | | | | 01240 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| Bentley Orbaugh Miller | | | | | | Month | Day | Year | 10:30 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | |
| Female | | White | | Feb. 15, 1882 | | 85 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Timberville, Va. | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Fairland Nursing Home | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2512 Kimberly Street | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First |
| John H. Orbaugh | | | | | | Mary Bowman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | (If yes: give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| No | | | | | 225-01-4816-2 | | Leona Miller Harrison 2512 Kimberly St. Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) _____ | | | | | | | | | |
| 2509 DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 260x | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1965, to Jan 11, 1968, that (I) (we) last saw the deceased alive on Jan 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Boris Rabkin | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 1/14/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| BORIS RABKIN | | | | | | 1019 Union Blvd. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Jan. 14, 1968 | | Woodbine Cemetery | | Harrisonburg, Virginia | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John B. Thomas | | | 8434 Georgia Ave. | | DATE JAN 15 1968 | | Charles Judge | | |
| Warner E. Pumphrey, Inc. | | | Silver Spring, Md. | | | | | | |

62870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

01241
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 4 Film G397 1/26/68 kk
CERTIFICATE OF DEATH

01241

| | | | | | | | |
|---|--|---|---|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Rebecca Miller</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>Jan 18 1968</i> | | | 2b. HOUR
<i>4:45 A.M.</i> | |
| 3. SEX
<i>Fe</i> | | 4. RACE
<i>Jewish White</i> | | 5. DATE OF BIRTH
<i>MAY-10 1898</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Poland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring, MD</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>1000 Doleview Dr. At the Woodland N.H.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>N.Y.</i> | | 13b. COUNTY
— | | 13c. CITY OR TOWN
<i>N.Y.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>387-GEORGIA AVE</i> | | 14. FATHER'S NAME First Middle Last
<i>ABRAHAM HERSH</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>UNKNOWN</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>090-286027</i> | | 17. INFORMANT
<i>Records. At the Woodland N.H.</i> | | Address
<i>1000 Doleview Dr Silver Spring, MD</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC PROTEINURIC KIDNEY DISEASE 67 YRS</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHRONIC BLOOD PRESSURE, OSCILLATES 100 YRS</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4200</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 DAYS</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>SOON INFECTION OF LUNG NIP</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 5, 1964</i> , to <i>Jan 18, 1968</i> , that (I) (we) lost the deceased alive on <i>1/16 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Donald Dole</i> | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1-18-68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Herold S. S. M.D.</i> | | 22e. ADDRESS
<i>352 UNIVERSITY BLVD E</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>1-19-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>NEW MONTGOMERY</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>FARMINGDALE, N.Y.</i> | |
| 24. FUNERAL DIRECTOR
<i>Deborah Freedman</i> | | ADDRESS
<i>4219 9th Ave</i> | | 25a. REC'D BY REGISTRAR
<i>JAN 23 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | |

2420

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|---------|--|---------------------------------------|---|--|---|--------------------------|---|---------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Ruth Louise Miller | | | | | | Jan 20 1968 | | | 5 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost, birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Female | W. | Nov 11, 1915 | 32 YRS. | MONTHS DAYS | HOURS MIN. | Jan 22 1968 | | | 12 PM | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | | | | |
| Iowa | | U.S.A. | | NEVER MARRIED | | Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | 4977 Battery Lane | | | | Fund Raiser | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | | Montgomery | | Bethesda | | YES NO | | 4977 Battery Lane Apt-608 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Louis A. Belsky | | | Bessie E. Kassler | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| (Yes, no, or unknown) | | | (If yes give war or dates of service) | | Robert Bell (Bro.) 3601 West Morning Side Ave. Santa Ana, Calif. 92703 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> Pulmonard edema & congestion | | | | | | | | | | 3 hr. ? | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>overdose of drugs - Elavil & Placidyl</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 9709 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES NO | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| PRIMARY OR CONTRIBUTING CAUSE OF DEATH | | | | ? P.M. Jan 20 19 68 | | Took overdose of drugs | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| WHILE AT WORK NOT WHILE AT WORK | | Apartment | | 4977 Battery Lane Bethesda | | Montg. | | Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | |
| John S. Ball | | | | M.D. | | | | 22 Jan 68 | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER | | | | ADDRESS (Street, city, town, or county) | | | |
| JOHN G. BALL | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Cremation | | 1-26-68 | | Cedar Hill Crematory | | Washington | | D.C. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Bernard Danzansky & Sons | | | | | | DATE | | JAN 29 1968 | | | |
| 3501 14th St. N.W. Wash. D.C. 20010 | | | | | | | | | | | |

01234

MEMORANDUM FOR THE RECORD

01234

01234

01234



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|--|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01243 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First MARY Middle Mobley Last | | | 2a. DATE OF DEATH
Month 1 Day 18 Year 68 | | | 2b. HOUR
11 P M | | |
| 3. SEX
F | | 4. RACE
Negro | | 5. DATE OF BIRTH
1-19-1890 | | 6. AGE (In years
last birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Cranford, S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Univ. Nurs. Home | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Teacher | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE D.C. | | | 13b. COUNTY
Wash DC | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1836 Newton St. N.E. | | |
| 14. FATHER'S NAME
First Dan Middle Mobley Last | | | 15. MOTHER'S MAIDEN NAME
First Mary Walker Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Ann Reeves - 1836 Newton Street, N. E. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
250.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral arterio sclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Nov. 1967 | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
260x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-20, 1967, to 1-19, 1968, that (I) (we) lost saw the deceased alive on 1-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Jenkins M.D. | | | | | 22c. DATE SIGNED
1-19-68 | | | 22d. PHYSICIAN'S NAME (Type) | | | |
| 22e. ADDRESS | | | | | 22f. REGISTRAR'S SIGNATURE
John T. Rhine | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
1-27-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Prince George, Maryland | | 23e. REC'D BY REGISTRAR
DATE JAN 26 1968 | | | |
| 24. FUNERAL DIRECTOR
John T. Rhine | | | | | | | | | | | |

1910

RECORD OF DATE

012210

George George, Maryland

George George, Maryland

George George, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01247 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01244 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Katherine Kreider Moser</i> | | | | | | | | | | 2a. DATE OF DEATH <i>January 14 1968</i> | | | | | | | | | | 2b. HOUR <i>8:34</i> AM | | | | | | | | | |
| 3. SEX <i>Female</i> | | | | | 4. RACE <i>White</i> | | | | | 5. DATE OF BIRTH <i>6-27-85</i> | | | | | 6. AGE (in years last birthday) <i>82</i> YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | | | | | | | | | | | |
| 1d. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | | 13b. COUNTY <i>Montgomery</i> | | | | | 13c. CITY OR TOWN <i>Bethesda</i> | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER <i>9207 Orion Road</i> | | | | | | | | | |
| 14. FATHER'S NAME First <i>August</i> Middle <i>Kreider</i> Last <i>Moser</i> | | | | | 15. MOTHER'S MAIDEN NAME First <i>Laura</i> Middle <i>Brigel</i> Last <i>Moser</i> | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i> (If yes give war and dates of service) | | | | | 16b. SOCIAL SECURITY NO. <i>No</i> | | | | | 17. INFORMANT <i>Katherine De Witt - above (daughter)</i> Address | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>471X RESPIRATORY ARREST</i> | | | | | | | | | | | | | | | | | | | | <i>5 MINUTES</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>480X</i> | | | | | | | | | | (b) <i>LOBAR PNEUMONIA</i> | | | | | | | | | | <i>6 DAYS</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) <i>INFLUENZA</i> | | | | | | | | | | <i>9 DAYS</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>EMPHYSEMA; UREMIA; ARTERIOSCLEROTIC HEART DISEASE</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 8</i> , 19 <i>68</i> , to <i>JAN 14</i> , 19 <i>68</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>JAN 14</i> , 19 <i>68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph D. Connor M.D.</i> DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <i>Jan. 14, 1968</i> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>JOSEPH D. CONNOR</i> | | | | | | | | | | 22e. ADDRESS <i>9420 Old Georgetown Rd. Bethesda, Md.</i> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | | | | | 23b. DATE <i>1-17-68</i> | | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cemetery</i> | | | | | 23d. LOCATION (City or Town) (County) (State) <i>Oxford North Carolina</i> | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557 Wisconsin Ave Bethesda, Md.</i> | | | | | | | | | | 25a. RECD BY REGISTRAR <i>JAN 18 1968</i> DATE | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | |

50310

[Faint handwritten notes, possibly bleed-through from the reverse side.]

01248

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01245

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) DORIS E MORRISON | | | 2a. DATE OF DEATH
Month JAN Day 8 Year 68 | | | 2b. HOUR 1:01 PM | |
| 3. SEX
FEMALE | | 4. RACE
CAU | | 5. DATE OF BIRTH
5-3-18 | | 6. AGE (In years last birthday)
49 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 1d. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
US NAVAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
WASH. D.C. | | 13b. COUNTY
3330 ERIE ST. S.E. | | 13c. CITY OR TOWN
WASH. D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3330--Erie St., SE | | | | | | | |
| 14. FATHER'S NAME
First James I. Middle Weeks | | | 15. MOTHER'S MAIDEN NAME
First Bertha M. Middle Fowler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Sister
Edith J. White Address Austin, Texas
5206-Buffalo Pass | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS
571.0
DUE TO, OR AS A CONSEQUENCE OF
(b) PEPSANGUINATION SECONDARY TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) ESOPHEAGEAL VERICOSITIES
2 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
unknown
3d. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5810 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 5 , 19 68 , to JAN 8 , 19 68 , that (I) (we) last saw the deceased alive on JAN 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C. S. CRUMMY | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
9 JAN. 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
C. S. CRUMMY | | | | 22e. ADDRESS
US NAVAL HOSPITAL, BETHESDA, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
Jan 12-68 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON, VA. | |
| 24. FUNERAL DIRECTOR
SIMMONS BROTHERS FUNERAL HOME | | | | 25a. REC'D BY REGISTRAR
1601 GOOD HOPE RD. S.E. WASH. D.C. | | 25b. REGISTRAR'S SIGNATURE
JAN 12 1968 | |

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---------------------------------|--|--|--------------|--|--|-----------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 01249 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 02858 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
MADELINE | | | Middle
H. | | | Last
MURRAY | | | 2a. DATE OF DEATH
Month
1 | | | Day
30 | | | Year
68 | | | 2b. HOUR
3:51 P.M. | | | | | |
| 3. SEX
FE | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
9-13-93 | | | 6. AGE (In years
last birthday)
74 | | | IF UNDER 1 YEAR
MONTHS
74 | | | IF UNDER 24 HRS.
HOURS
74 | | | MIN.
74 | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
ILLINOIS | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
MONTGOMERY | | | Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
BETHESDA-SILVER SPRING HOME | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR
INDUSTRY
AT HOME | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
ILLINOIS | | | 13b. COUNTY
CHICAGO | | | 13c. CITY OR TOWN
CHICAGO | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
3580 LAKE SHORE DR. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
PATRICK | | | Middle
HEALEY | | | Last
MARY | | | 15. MOTHER'S MAIDEN NAME
First
GERRAN | | | Middle
Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
UNKNOWN | | | 17. INFORMANT
PATIENT'S CHART | | | Address | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
<u>174X</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Ca Breast</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>9 months</u>
<u>1 year</u> | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>170X</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> , to <u>Jan 31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>J E Fitzgerald</u> | | | 22c. DEGREE
M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22d. ADDRESS
3750 Reservoir Rd NW Wash DC | | | 22e. ADDRESS | | | 22f. ADDRESS | | | 22g. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
1-31-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
CALVARY CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
EVANSTON, ILL | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
WW Chambers Co | | | ADDRESS
1400 Chapin | | | 25a. REC'D BY REGISTRAR
W. J. Chambers | | | 25b. REGISTRAR'S SIGNATURE
W. J. Chambers | | | DATE
FEB 13 1968 | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

01250

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01246

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|---------|--|
| 1. DECEASED-NAME
(Type or print) MATILDA J. MURRAY | | | 2a. DATE OF DEATH
JAN Month 27 Day 68 Year | | | 2b. HOUR
12 35 A M | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/1/01 | | 6. AGE (In years
lost birthday)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
HOLY CROSS HOSP. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR
INDUSTRY
AT HOME | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
MARYLAND | | 13b. CITY OR TOWN
FAIRFAX | | 13c. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
6311 SLIGO PARKWAY | | | | |
| 14. FATHER'S NAME
First Middle Last
AUGUST NAGALE | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY - LUTZ (AS LIE) | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
148-24-5557M | | | 17. INFORMANT
JAMES W MURRAY | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Urinary Tract infection, sepsis
436.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Stroke DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arteriosclerosis, RMO C A.S. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
weeks
73 months
Years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
334X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1967 , to Jan. 26, 1968 , that (I) (we) last saw the deceased alive on Jan. 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
G. Graziani, M.D.
for Dr. Thomas Fogarty | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/27/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Hu 40 G. GRAZIANI, M.D. | | 22e. ADDRESS
19101 Georgia Ave, SS. Md. | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
1-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION (City or Town) (County) (State)
WHEATON MD | | | | |
| 24. FUNERAL DIRECTOR
222 Chambers & 1400 Chapman St | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

ALSO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01251

CERTIFICATE OF DEATH

01247

| | | | | | | | |
|--|--|---|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) WILLIAM ANTHONY NEACEY | | | 2a. DATE OF DEATH
Month JAN Day 21 Year 68 | | | 2b. HOUR
3:50 M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
7-27-96 | | 6. AGE (In years last birthday)
71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
WASH. DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Lawyer | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN CHEVY CHASE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
206 PRIMROSE ST. | | | | | | | |
| 14. FATHER'S NAME First James Middle Neacey Last Neacey | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last Crawling | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give war or dates of service)
WW II | | | 16b. SOCIAL SECURITY NO.
Yes | | 17. INFORMANT
Gertrude J. Neacey Address 206 Primrose Street, Chevy Chase, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
2000 DUE TO, OR AS A CONSEQUENCE OF
(b) Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Reticulum Cell Sarcoma
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 Min
2 days
3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
2000 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10 , 1967, to 1/21 , 1968, that (I) (we) last saw the deceased alive on 1/20 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Thomas O'Connor MD DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/21/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas O'Connor | | | | 22e. ADDRESS
8218 Wisconsin Ave Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince George Co., Md. | |
| 24. FUNERAL DIRECTOR
C. Glen Carter | | ADDRESS
8434 Georgia Ave. | | 25a. REC'D BY REGISTRAR
Warner E. Pumphrey, Inc. | | 25b. REGISTRAR'S SIGNATURE
Warner E. Pumphrey | |
| DATE JAN 25 1968 | | | | | | | |

01252

01248

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|------------------------|--|---|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Harry Russell Newton</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>JAN.</i> Day <i>1</i> Year <i>1968</i> | | | 2b. HOUR <i>11:30</i> M <i>A</i> | | | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>Cauc</i> | 5. DATE OF BIRTH
<i>7/31/1888</i> | 6. AGE (In years last birthday)
<i>79</i> YRS. | IF UNDER 1 YEAR
MONTHS <i> </i> DAYS <i> </i> | IF UNDER 24 HRS.
HOURS <i> </i> MIN. <i> </i> | 2c. DATE PRONOUNCED DEAD
Month <i>1</i> Day <i>1</i> Year <i>1968</i> | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Tenn.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)
<i>Fairland Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Banker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Banking</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
First <i>James</i> Middle <i>A.</i> Last <i>Newton</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Charlotte</i> Middle <i> </i> Last <i>Gurthner</i> | | | 13e. STREET AND NUMBER
<i>701 Quaint Acres Drive</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | | 16b. SOCIAL SECURITY NO.
<i>413-16-38484</i> | | 17. INFORMANT
<i>Mrs. Robert R. Newton</i> | | | | |
| 16c. ADDRESS
<i>70 Quaint Acres Dr. Silver Spring, Md.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i> </i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR <i>19</i> A.M. <i>P.M.</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Belden R. Reap</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<i>JAN. 1, 1968</i> | | | |
| EXAMINER'S NAME (Type)
<i>BELDEN R. REAP, M.D.</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ADDRESS
<i>4001 Georgia Ave. Silver Spring, Md.</i> | | | ADDRESS (Street and town or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Trans-burial</i> | | 23b. DATE
<i>Jan 4 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Highland Memorial Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Knoxville Tennessee</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Humphrey, Inc.</i> | | ADDRESS
<i>8011 Georgia Ave. Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

01523
01510

3/11/53
3/11/53

1-1-1953
1-1-1953

1-1-1953
1-1-1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Hall - Medical Examiner notified

| | | | | | | | |
|---|--|--|--|---|------------------------------------|---|--|
| 01253 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01249 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Francis W. Morris | | | 2a. DATE OF DEATH
Month 8 Day 1968 | | | 2b. HOUR
3:29 PM | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
4/1/1893 | | 6. AGE (In years last birthday)
74 | |
| 7a. BIRTHPLACE (State or foreign country)
Marion, Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban Engineering, Mech. Private. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Private. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Montgomery | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
5012 Aspen Hill Rd. | | 13f. CITY OR TOWN
Rockville | | 13g. STATE
Md. | | 13h. ZIP CODE
20850 | |
| 14. FATHER'S NAME First Middle Last
Richard F. Morris | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Elizabeth Maher | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
yes | | | 16b. SOCIAL SECURITY NO.
W-17-44276-09-340 | | 17. INFORMANT
Richard A. Morris | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
4360 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1967, to Jan. 8, 1968, that (I) (we) lost the deceased alive on Jan. 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John C. K. Yu M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
Jan. 8, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
John C. K. Yu | | | | 22e. ADDRESS
4912 Adrian St., Rockville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Marion, Ohio | |
| 24. FUNERAL DIRECTOR
C. Glen Carter 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

01310

CERTIFICATE OF SALE

01310

[Faint, mostly illegible text, likely a certificate of sale or deed, with some handwritten notes and signatures.]

RECORDING DEPARTMENT
COUNTY OF LOS ANGELES
CALIFORNIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | |
|--|--|---|---|--|---|
| 01254 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01250 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN lb
2 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | | d. STREET ADDRESS
10217 LESLIE ST. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) WILLIAM C. O'CONNELL | | | 4. DATE OF DEATH
Month JAN Day 1 Year 1968 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/6/90 | 9. AGE (In years last birthday)
77 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plumber | | 10b. KIND OF BUSINESS OR INDUSTRY
Plumbing | | 11. BIRTHPLACE (County & State, or foreign country)
NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
Michael O'Connell | | |
| 14. MOTHER'S MAIDEN NAME
Catherine Bond | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) WWI (If yes give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
089-07-7995 | | | 17. INFORMANT
Address Mrs. James J. Gorman, Daughter Same as #2 above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
4409 DUE TO CONGESTIVE HEART FAILURE.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) ARTERIO SCLEROSIS
(c) ARTERIO SCLEROSIS | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
4500 DIAPHRAGMATIC DIVERTICULITIS | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "a.m." p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6/1 , 19 67 , to 1/1 , 19 68 , that (I) (we) lost the deceased alive on 12/31 19 67 , and that death occurred at 325A AM, from causes on and on the date stated above. | | | | | |
| 22a. SIGNATURE
Henry W. Stout M.D. | | | 22b. DATE SIGNED
1/1/68 | | 22c. PHYSICIAN'S NAME (Type)
Henry W. Stout M.D. |
| 22d. ADDRESS
10011 GEORGIA AVE SILVER SPRING MD | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | |
| 23b. DATE THEREOF
1/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Charles Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suffolk County, L.I., N.Y. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | 25a. REC'D BY REGISTRAR
Washington, D. C. | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge |

01254

STATEMENT OF DEATH

01254

WEST GORSELEY
SILVER SPRING & SONS
HOLY CROSS HOSPITAL
WILLIAM O. O'CONNELL
M W X
1/2/90
NEW YORK

DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
AGE
SEX
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
BIRTH
DEATH
SIGNATURE
WITNESSES
DOCTOR
CITY
STATE
COUNTY
JURY
FINDINGS
VERDICT
JURY
FINDINGS
VERDICT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01255 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01251 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|---------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First
KATHARINE | | | | | | | | | | Middle
LEE | | | | | | | | | | Last
OGILVIE | | | | | | | | | | Month
JAN. | | | | | | | | | | Day
11, | | | | | | | | | | Year
1968 | | | | | | | | | | 7:30 PM | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
Caucasian | | | | | | | | | | 5. DATE OF BIRTH
Feb. 14, 1894 | | | | | | | | | | 6. AGE (In years
last birthday)
73 | | | | | | | | | | IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. | | | | | | | | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
New York | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery, | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
9304 Elmhurst St. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Retired | | | | | | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Hair Dresser | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | | | | | | | 13b. COUNTY
Montg. | | | | | | | | | | 13c. CITY OR TOWN
Bethesda | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
9304 Elmhurst St. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
John | | | | | | | | | | Middle
J. | | | | | | | | | | Last
Lee | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
First
Katharine | | | | | | | | | | Middle
Allen | | | | | | | | | | Last
Allen | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
NO | | | | | | | | | | (If yes give war or dates of service)
----- | | | | | | | | | | 16b. SOCIAL SECURITY NO.
578-46-7636 | | | | | | | | | | 17. INFORMANT
Mrs. Geo. Christensen, Bethesda, Md. | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>471X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>480X</u>
(b) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>LOBAR PNEUMONIA</u>
(c) <u>INFLUENZA</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 MINUTES</u>
<u>2 WEEKS</u>
<u>3 WEEKS</u> | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>GENERALIZED ARTERIOSCLEROSIS</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 19a. DATE OF OPERATION
<u>None</u> | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>None</u> | | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 1, 1967</u> , to <u>JAN 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
<u>Joseph D. Connor M.D.</u> | | | | | | | | | | 22c. DATE SIGNED
<u>January 11, 1968</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>JOSEPH D. CONNOR, M.D.</u> | | | | | | | | | | 22e. ADDRESS
<u>9420 OLD GEORGETOWN RD. BETHESDA</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | | | | | | 23b. DATE
<u>1/15/68</u> | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Md.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. BURIAL DIRECTOR
<u>Jos. Gawler's Sons, Washington, D.C.</u> | | | | | | | | | | ADDRESS
<u>5130 Wisconsin Ave. N.W.</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR
<u>JAN 18 1968</u> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

01351

01351

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01256 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01252 | |
|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First Middle Last
JULIAN MEADE OSBORNE | | 2a. DATE OF DEATH
JAN Month 5 Day 1968 or
2b. HOUR
850P M | |
| 3. SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
20 JULY 1918 | |
| 6. AGE (In years last birthday)
49 YRS. | | 7. AGE (In years last birthday)
49 YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 9. COUNTY OF DEATH
MONTGOMERY | | 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
USAF | | 12b. KIND OF BUSINESS OR INDUSTRY
USAF | | 13. CITY OR TOWN
MCLEAN | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
VIRGINIA | | 13b. COUNTY
MCLEAN | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
JULIAN PLESANTS OSBORNE | | 15. MOTHER'S MAIDEN NAME
First Middle Last
ELIZABETH IRVING | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES 1942-1968 | |
| 17. SOCIAL SECURITY NO.
218 05 4899 | | 18. INFORMANT
Address
MARGARET M. OSBORNE 1707 OAK LANE MCLEAN, VA. | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
56 DAYS | |
| 20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | 21. DATE OF OPERATION
10 NOV 1967 | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED
10 NOV 1967 | |
| 23. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | 25. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, natly medical examiner) | |
| 26. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 27. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 28. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 29. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 30. LOCATION
Street or R.F.D. No. City or Town County State | | 31. I certify that (I) (this hospital) attended the deceased from 10 NOV 1967 , to 5 JAN 1968 , that (I) (we) last saw the deceased alive on 5 JAN 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 32. SIGNATURE
J. E. Zimmerman MD DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 33. DATE SIGNED
6 JAN 1968 | | 34. PHYSICIAN'S NAME (Type)
J. E. ZIMMERMAN LT MC USN | |
| 35. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. | | 36. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 37. DATE
1-10-68 | |
| 38. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 39. LOCATION (City or Town) (County) (State)
ARLINGTON, ARLINGTON, VA. | | 40. REGISTRAR'S SIGNATURE
Charles Judge | |
| 41. REGISTRAR'S SIGNATURE
Charles Judge | | 42. DATE
JAN 11 1968 | | 43. REGISTRAR'S SIGNATURE
Charles Judge | |

01350

STATE OF DEATH

01350

DEATH CERTIFICATE

DATE

TIME

AGE

SEX

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

CAUSE

DIAGNOSIS

DATE

SIGNATURE

DEATH CERTIFICATE

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH CERTIFICATE ACT

1964-1965

DEATH CERTIFICATE

83-01-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|
| 01257 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 01253 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Mae Lenora Owens</i> | | | First Middle Last | | | 2. DATE OF DEATH
Month Day Year | | 2b. HOUR
5:55 P.M. | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Negro</i> | | 5. DATE OF BIRTH
<i>10/27/01</i> | | 6. AGE (In years
last birthday)
<i>66</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Suburban</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Domestic</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>802 Stone St. Ave</i> | |
| 14. FATHER'S NAME
<i>William Hedron</i> | | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
<i>Bessie Johnson</i> | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>217-30-0185</i> | | 17. INFORMANT
<i>Genie Hedron</i> | | | Address <i>11 St. Anselm
Rockville Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary infarctions</i>
<i>450x</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <i>465x</i>
(b) <i>Pulmonary artery thrombosis, old and recent</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>3 weeks</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Nephrotic syndrome due to Kimmelstiel-Wilson Disease</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>67</i> , to <i>Jan 10</i> , 19 <i>68</i> , that (I) (we) last
saw the deceased alive on <i>Jan 10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Marvin Wadler</i> | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>1/11/68</i> | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<i>MARVIN WADLER</i> | | | | | 22e. ADDRESS
<i>8218 Winc. Av. Beth., Md.</i> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>Jan 15, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lincoln Park Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Montg. Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>ELMER R. Snowden</i> | | | | | ADDRESS
<i>Rockville</i> | | 25a. REC'D BY REGISTRAR
<i>Charles Jones</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | |
| JAN 18 1968 | | | | | | | | | | |

01323

OFFICE OF THE ATTORNEY GENERAL

01323



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|-----------------------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR |
| Bessie. | | Bonney | | Page. | | | | Month Day Year | | 10 P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD |
| Fe. | W. | 8/7/1874 | | 93 YRS | | MONTHS DAYS | | HOURS MIN. | | Month Day Year |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | 2d. HOUR |
| Indiana | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery | | 10 P M |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Kensington. | | Carroll Hall Nursing Home. | | | | Homemaker | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | |
| Washington, D. C. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1801 Park Rd. N. W. | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Byron | | W. | | Bonney | | Emma | | Keffer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| no | | 577-60-8011 | | T Mr. Ralph Keffer | | 42 Four Mile Rd. W. Hartford, Conn. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - | | | | | | | | | | 4 days - |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Back injury - | | | | | | | | | | 9 weeks - |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Vascular Disease - | | | | | | | | | | years - |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 9040 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | 7 P.M. Nov. 11 1967 | | Fall in home injuring lower back. | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Home | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | John G. Ball | | | | CHIEF MEDICAL EXAMINER | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | John G. Ball | | | | ASSISTANT MEDICAL EXAMINER | | Jan. 18, 1968 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Cremation | | 1/18/68 | | Ft. Lincoln Crematory | | Prince Georges Co. | | Md. | | |
| 24. FUNERAL DIRECTOR | | The S. H. Hines Co. | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | Washington, DC | | JAN 22 1968 | | Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

01259

01255

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Carl Dean Palmisiano | | | 2a. DATE OF DEATH
1 Month 17 Day 68 Year | | 2b. HOUR
3:05 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
1-15-68-3 AM | | 6. AGE (In years last birthday)
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Montgomery | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hos pital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
12904 SHADLER BRACK DRIVE | |
| 14. FATHER'S NAME
First Carl Middle L. Palmisiano Last Domenica | | 15. MOTHER'S MAIDEN NAME
First Nathryn Middle D'Agostino Last D'Agostino | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
NONE | 17. INFORMANT
Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7468 Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypoplastic Left Heart Syndrome
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
47 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
7545 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION | Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1968 , to Jan. 17, 1968 , that (I) was lost sow the deceased olive on Jan. 16, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Leonard Lefkowitz, M.D. | | DEGREE | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
17 Jan. 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
LEONARD LEFKOWITZ | | 22e. ADDRESS
2390 Glenmont Circle Silver Spring Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
Jan. 18, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | 23d. LOCATION (City or Town) | (County) | (State)
Silver Spring Mont., Md. |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | ADDRESS
8434 Georgia Avenue Silver Spring, Md. | 25a. REC'D BY REGISTRAR
DATE
JAN 22 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1. The first part of the report is a general statement of the facts of the case. It is a summary of the evidence and the arguments of the parties. It is a statement of the facts of the case as they appear to the court. It is a statement of the facts of the case as they appear to the court.

2. The second part of the report is a statement of the law applicable to the facts. It is a statement of the law as it applies to the facts of the case. It is a statement of the law as it applies to the facts of the case.

3. The third part of the report is a statement of the court's decision. It is a statement of the court's decision on the facts of the case. It is a statement of the court's decision on the facts of the case.

4. The fourth part of the report is a statement of the court's reasons for its decision. It is a statement of the court's reasons for its decision on the facts of the case. It is a statement of the court's reasons for its decision on the facts of the case.

5. The fifth part of the report is a statement of the court's conclusions. It is a statement of the court's conclusions on the facts of the case. It is a statement of the court's conclusions on the facts of the case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01260 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01256 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First <i>Annunziata</i> Middle <i>Pan</i> Last <i>Panzerio</i> | | | | | | | | | | 1 Month 13 Day 68 Year | | | | | | | | | | 2 15 A M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| FEMALE | | | | | | | | | | Causa | | | | | | | | | | 7-21-1883 | | | | | | | | | | 68 Yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| ITALY | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Montgomery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| wheaton | | | | | | | | | | University Nurses Home | | | | | | | | | | Housewife | | | | | | | | | | OWN HOME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | mont. | | | | | | | | | | HIGHTMAN | | | | | | | | | | YES | | | | | | | | | | BROOKS ROAD | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Antonio | | | | | | | | | | Carbone | | | | | | | | | | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | | | | | | | | 072-095687 | | | | | | | | | | Dr. Paul P. Carbone | | | | | | | | | | Brooks Road, Highland Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Cerebral Vascular Accident | | | | | | | | | | | | | | | | | | | | Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4129 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) Right Middle Lobe Pneumonia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10, 1968, to 1-13, 1968, that (I) (we) last saw the deceased alive on 1-12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. J. Lieberman | | | | | | | | | | 11/13/67 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. J. Lieberman | | | | | | | | | | 6124 Central Avenue - Bk of Ph. Med | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | January 16, 1968 | | | | | | | | | | Mt. Calvary Cemetery | | | | | | | | | | White Oak Plains New York | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. Ellen Carter | | | | | | | | | | DATE JAN 18 1968 | | | | | | | | | | J. Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Warner E. Humphrey Inc. 8434 Georgia Avenue SS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

01301

01301

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY FOR CATTLE AND EQUINE

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01262

CERTIFICATE OF DEATH

01258

| | | | | | | | |
|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Wilbur Owen Parsley | | | 2a. DATE OF DEATH
January Month 10 Day 1968 Year | | | 2b. HOUR
7:00PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Aug. 5, 1892 | | 6. AGE (In years last birthday)
75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Landolf Hills Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Gov't. Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
8800 1st. Ave. | | 14. FATHER'S NAME First Middle Last
Otho Parsley | | 15. MOTHER'S MAIDEN NAME First Middle Last
Christina Mulligan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) Yes | | 16b. SOCIAL SECURITY NO.
WW1 | | 17. INFORMANT
Nellie W. Parsley-same item # 13 --wife | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
485X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966/12/26 , to 1/10/68 , 19____, that (I) (we) last saw the deceased alive on 1/10/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Henry C. Scruggs | | | | DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Henry C. Scruggs | | | | 22e. ADDRESS
5413 Cedar Lane, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville Montgomery Md | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | | | ADDRESS
1331 Rock. Pike Rockville, Md. | | 25a. REC'D BY REGISTRAR
JAN 16 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Film 397
1-25-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
01263 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01259

| | | | | | |
|---|----------------------|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) VERNON RICHARD PARSONS | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1-14 Year 1968 | | 2b. HOUR M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 10-23-1948 | 6. AGE (In years lost birthday) 19 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH MONTGOMERY | | Md. | | | |
| 10. CITY OR TOWN OF DEATH SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12505 BUSHEY DR. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY MONT. | | 13c. CITY OR TOWN S.S. | |
| 14. FATHER'S NAME Arthur Parsons | | 15. MOTHER'S MAIDEN NAME Dolly Mar Rosencrans | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16b. SOCIAL SECURITY NO. 500 16 5839 | | 17. INFORMANT ADDRESS Louise L. Parsons-wife- same item #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Right Coronary Thrombosis with occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 19 HOURS AM P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | M.D. | | 22b. DATE SIGNED JAN. 15, 1968 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP | | M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or County) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home | | ADDRESS 1331 Rockville Road, Rockville, Md. | | 25a. REC'D BY REGISTRAR JAN 18 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

[Faint, mostly illegible text in the main body of the report, appearing to be a series of paragraphs or a list of items.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01264 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01260 | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------|--|--|--|--|---------------------------|--|--|--|--|--------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First
Charles | | | | | Middle
(None) | | | | | Last
Pavelka | | | | | 2a. DATE OF DEATH
Month
January | | | | | Day
29 | | | | | Year
1968 | | | | | 2b. HOUR
3:55 PM | | | | |
| 3. SEX
Male | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
6 September 1910 | | | | | 6. AGE (In years
lost birthday)
57 YRS. | | | | | IF UNDER 1 YEAR
MONTHS | | | | | IF UNDER 24 HRS.
DAYS | | | | | IF UNDER 24 HRS.
HOURS | | | | | IF UNDER 24 HRS.
MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Czechoslovakia | | | | | 7b. CITIZEN OF WHAT COUNTRY?
Canada | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Shipping Receiver | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Steel | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Canada | | | | | 13b. COUNTY
Ontario | | | | | 13c. CITY OR TOWN
Hamilton | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
231 McNab Street South | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Charles | | | | | Middle
Pavelka | | | | | Last
Albertina | | | | | 15. MOTHER'S MAIDEN NAME
First
Cernochova | | | | | Middle
Last | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | | | (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO.
None | | | | | 17. INFORMANT
The Medical Record Address
The Clinical Center, Bethesda, Maryland | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure</u>
<u>3960</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <u>Bacterial Endocarditis</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Rheumatic heart disease status post</u>
(c) <u>aortic and mitral valve replacement</u> | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 months | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | 2 1/2 months | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<u>410 X</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 26</u> , 19 <u>67</u> , to <u>Jan. 29</u> , 19 <u>68</u> , that (X) (we) last
saw the deceased alive on <u>Jan. 29</u> , 19 <u>68</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Willis H. Williams M.D.</u> DEGREE | | | | | | | | | | | | | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
January 30, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) Willis H. Williams, M.D. | | | | | | | | | | | | | | | 22e. ADDRESS
The Clinical Center, National
Institutes of Health, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial-Transit | | | | | 23b. DATE
1/30/1968 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepulcher | | | | | 23d. LOCATION (City or Town) (County) (State)
Ontario, Canada | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home
1331 Rockville Pike, Rockville, Md. | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE Feb 2 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | |

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RECEIVED BY MAIL

Canada

Ontario

North York

Post Office

Post Office

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01265

01261

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | |
|---|------------------|--|---|---|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> Month Day Year
Jan. 24 1968 | | | 2b. HOUR
3:15 PM | | | |
| Dorothy Beach Peirce | | | | | | | | | | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
5/25/91 | 6. AGE (In years last birthday)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Jan. Day 24 Year 68 | | | 2d. HOUR
4:30 PM | |
| 7a. BIRTHPLACE (State or foreign country)
Conn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3378 Chiswick Court | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3378 Chiswick Court | | | | |
| 14. FATHER'S NAME
Isaac Eaton Beach | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
Dorothy x Jenny Davis | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
unknown | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
578-62-4954 | | 17. INFORMANT
E.A. taken from records Montgomery General Hospital | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 412.0 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Beldon R. Reap, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
JAN. 24, 1968 | | | |
| EXAMINER'S NAME (Type)
Beldon R. Reap, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county)
Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
Jan. 25, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | | 23d. LOCATION (City or Town) (County) (State)
Prince George Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR
John B. Thomas, Jr. 34 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

FOR STATE
HEALTH DEPT.

Item 5 Film G397 1/20/68 k

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01262

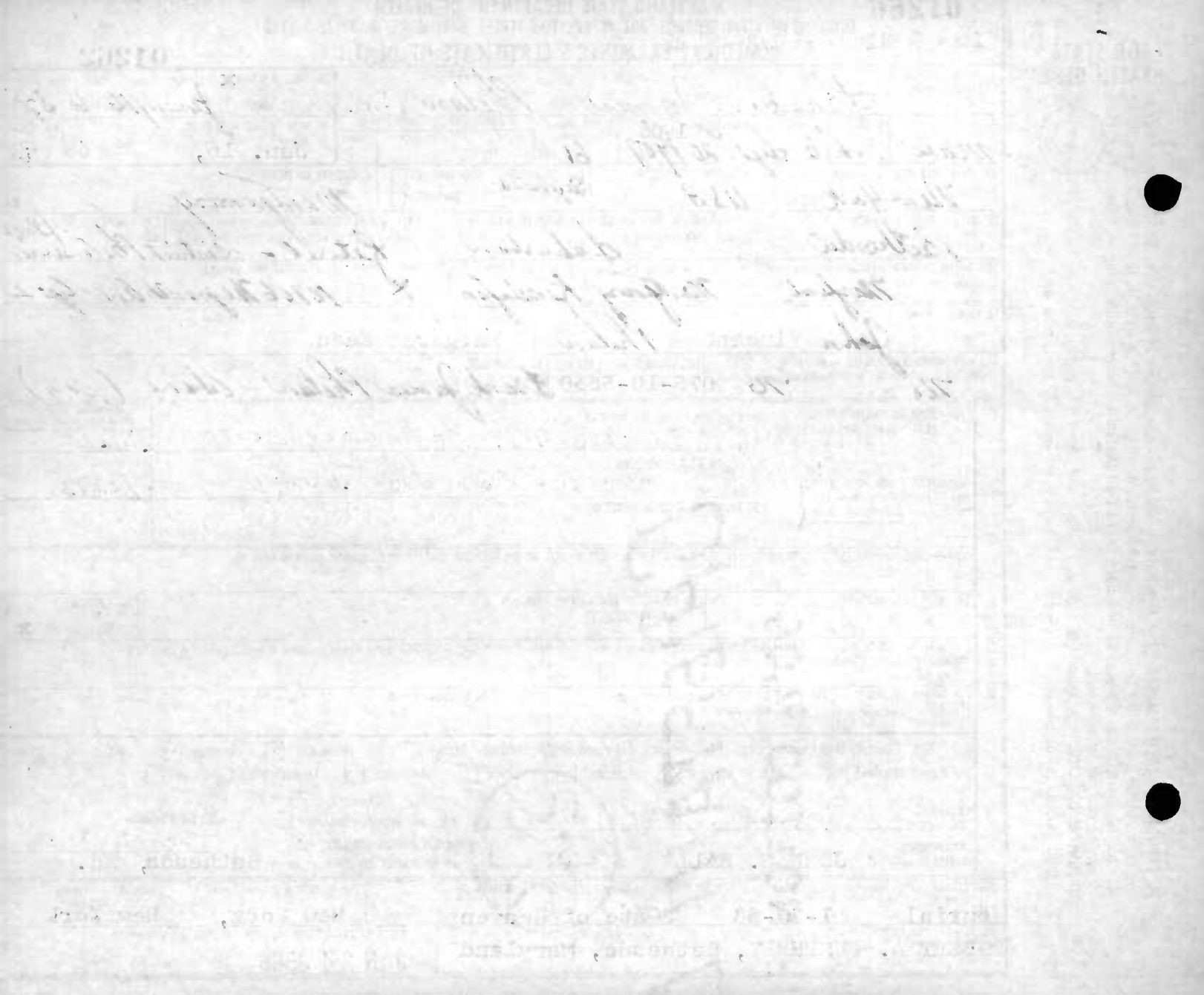
| | | | | | | | | |
|--|-------------------------|---|--|---|------------------|---|--|---|
| 1. DECEASED-NAME
(Type or Print) <i>Francis James Phelan, SR.</i> | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <i>January 16 1968</i> | | | 2b. HOUR OF ESTI-
DEATH MATED <i>8:55 PM</i> | | |
| 3. SEX
<i>male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
<i>Apr. 20 1907</i> | 6. AGE (In years
last birthday)
<i>61</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
Month Day Year <i>Jan. 16, 1968</i> | | 2d. HOUR
<i>8:25 PM</i> |
| 7a. BIRTHPLACE (State or foreign
country) <i>New York</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>Separated</i> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<i>Retired - District Photo Service</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Kearnsen</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>10706 Keyworth Ave - Apt 2</i> |
| 14. FATHER'S NAME
First Middle Last <i>John Vincent Phelan</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last <i>Margaret Reed</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
(If yes give wage or date of service) <i>76 075-10-5650</i> | | 17. INFORMANT
<i>Frank James Phelan - Above (son)</i> | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Insufficiency - Acute.</i>
<i>4129</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cardio-Vascular Disease.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>Sudden.</i>

<i>Years.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL
SIGNATURE <i>John G. Ball</i> | | EXAMINER'S
NAME (Type) <i>JOHN G. BALL</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<i>Jan. 17, 1968</i> | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1-20-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>New York, New York</i> | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 24 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01267 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01263 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Mary Germaine Piggott | | | | | | | | | | 2a. DATE OF DEATH Month 1 Day 30 Year 68 | | | | | | | | | | 2b. HOUR 9:05 M | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH 10/28/12 | | | | | 6. AGE (In years lost birthday) 55 YRS. | | | | | IF UNDER 1 YEAR MONTHS 55 DAYS 55 | | | | | IF UNDER 24 HRS. HOURS 55 MIN 55 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Penn. | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross | | | | | 12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) Operator | | | | | 12b. KIND OF BUSINESS OR INDUSTRY C + P Tel. | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | | 13b. COUNTY Montgomery | | | | | 13c. CITY OR TOWN Wheaton | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 2618 Weisman Rd. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First John Middle P. Last Leib | | | | | 15. MOTHER'S MAIDEN NAME First Margaret Middle Callan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | | | 16b. SOCIAL SECURITY NO. 577-05-5626 | | | | | 17. INFORMANT John Piggott Address 2618 Weisman Road Wheaton, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 Massive Subarachnoid Hemorrhage | | | | | | | | | | | | | | | Over 24 Hrs | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension | | | | | | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 330X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 29 , 19 68 , to Jan 30 , 19 68 , that (I) (we) last saw the deceased alive on Jan 30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Hugh G. Graziani, MD. | | | | | | | | | | DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 1/30/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI, MD. | | | | | | | | | | 22e. ADDRESS 10101 Georgia Ave Silver Sp. Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE Feb. 3, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | | | | | | | | | ADDRESS 8434 Georgia Ave. Silver Spring, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |
| DATE FEB 5 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Jimmy Wayne Poole</i> | | | 2a. DATE OF DEATH
Month <i>January</i> Day <i>2</i> Year <i>1968</i> | | | 2b. HOUR
<i>11:20 AM</i> | | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>23 December 1966</i> | | 6. AGE (In years
lost birthday) <i>1</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | 8. IF UNDER 24 HRS.
HOURS <i></i> MIN <i></i> | |
| 7a. BIRTHPLACE (State or foreign
country) <i>South Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <i>The Clinical Center</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>none</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>none</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>S.C.</i> | | 13b. COUNTY
<i>Salley</i> | | 13c. CITY OR TOWN
<i>Salley</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Route 1 Box 176B</i> | | | |
| 14. FATHER'S NAME
First <i>Bobby</i> Middle <i>W.</i> Last <i>Poole</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Shirley</i> Middle <i></i> Last <i>Smith</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>none</i> | | 17. INFORMANT <i>Medical Records</i> Address
<i>The Clinical Center, Bethesda, Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Septicemia</i>
<i>0381</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <i>Pneumonitis (Staph. Aureus)</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Congenital Heart Disease</i> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>5 days</i>
<i>10 days</i>
<i>1 Year</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>0531</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>28 Sept</i> , 19 <i>68</i> , to <i>2 Jan</i> , 19 <i>68</i> , that <i>as</i> (we) last
saw the deceased alive on <i>2 January</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>J. E. A. Fuchs</i> MD DEGREE | | | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
<i>4 January 1968</i> | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>James C.A. Fuchs, MD</i> | | | | | 22e. ADDRESS <i>The Clinical Center National
Institutes of Health, Bethesda, Maryland</i> | | | | | | |
| 23a. BURIAL CRYPTS
Specify <i>Burial</i> | | 23b. DATE
<i>Jan 5, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Clinton Methodist Ch</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Wagener, Aiken, South Car'l</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc. Silver Spring, Md</i> | | | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 8 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>P. Clonker, Judge</i> | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-700. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|-------------------|---|--|--|--|--|----------------------------|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) Arthur Murray Preston | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan Day 7 Year 1968 | | | 2b. HOUR 10:15 A.M. | | | | | |
| 3. SEX M. | 4. RACE W. | 5. DATE OF BIRTH Nov. 1, 1913 | 6. AGE (In years last birthday) 54 YRS. | IF UNDER 1 YEAR
MONTHS 54 DAYS 00 HOURS 00 MIN. | 2c. DATE PRONOUNCED DEAD
Month Jan Day 7 Year 1968 | | 2d. HOUR 10:30 A.M. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | | | Md. | |
| 10. CITY OR TOWN OF DEATH Cherry Chase | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4001 Thornapple St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Vice President | | 12b. KIND OF BUSINESS OR INDUSTRY Banking | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Cherry Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4001 Thornapple St. | | | |
| 14. FATHER'S NAME First Orcl. Middle Preston Last Preston | | | 15. MOTHER'S MAIDEN NAME First Carolyn Middle Murray Last Murray | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | (If yes give war or dates of service) 1941-1945 | | 16b. SOCIAL SECURITY NO. 577-12-9368 | | 17. INFORMANT Wife - Elizabeth Preston | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot Wound of Head
955 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
976 X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 10:15 A.M. Jan. 7 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot Self in head with 38 cal Revolver. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No. 4001 Thornapple St. Cherry Chase Mont. Md | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John G. Ball | | EXAMINER'S NAME (Type) | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | | | ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED Jan 7, 1968 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery | | 23d. LOCATION (City or Town) Arlington, Va. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | | | ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C. | | 25a. REC'D BY REGISTRAR JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | | | |

01300

RECEIVED

01300

JAN 1 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01270

01266

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dawsonville | | c. LENGTH OF STAY IN lb
3 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sugarland Road | | d. STREET ADDRESS
Sugarland Road | |
| 3. NAME OF DECEASED
(Type or print) ROBERT E. PRIEST, Sr. | | 4. DATE OF DEATH
Month Jan. Day 1, Year 19 68 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 21, 1917 |
| 9. AGE (In years lost birthday) yrs. 50 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Landscape Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
Penna. | |
| 11. BIRTHPLACE (County & State, or foreign country)
U. S. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Pe rcy Priest | | 14. MOTHER'S MAIDEN NAME
Josephine Shaw | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes. WW II | | 16. SOCIAL SECURITY NO.
175-01-9633 | |
| 17. INFORMANT wife
Ruth Priest | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
412.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
1964 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
4201 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 19 52 , to present , 19 68 , that (I) (we) last saw the deceased alive on July , 19 67 , and that death occurred at 7 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
George Sharpe | | 22b. DATE SIGNED
1-1-68 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE SHARPE | | 22d. ADDRESS
10400 Conn. Ave. Kensington, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1-4-68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Darnestown, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
JAN 5 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

01210

01210

TECHNICAL DEPT.

DEC. 21, 1957

11-01-0000

1-51

JAN 1 1958

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the

VR A15 (4)
30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|---|
| Item 14 Film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 3/5/68 ap 01272 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01268 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Adele V Pruitt | | | | | 2a. DATE OF DEATH Month Day Year
JANUARY 15 1968 | | | 2b. HOUR
8 42 A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7-11-1897 | | 6. AGE (In years lost birthday)
70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT-HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Langley Pk | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8116-15th AVE | |
| 14. FATHER'S NAME First Middle Last
Willet J. Sybert | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARY V STROTHER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
578-40-8343A | | 17. INFORMANT Address AS
MARY V. CROVO 13E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Artery Thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Artery Atherosclerosis
10 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1d. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 8, 1967 , to 1/15, 1968 , that (I) (we) last saw the deceased alive on 1/15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
G. Lenard Gold | | | | | 22c. DATE SIGNED
1/15/68 | | 22d. PHYSICIAN'S NAME (Type)
G LENARD GOLD | | |
| 22e. ADDRESS
HOLY CROSS HOSPT | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
1-18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM | | 23d. LOCATION (City or Town) County State
SUITLAND GDS MD | | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co. | | | | | ADDRESS
1400 Chapin N. | | 25a. REC'D BY REGISTRAR
JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] |

01373

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|-----------------------------------|--|--|--|
| 01273 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01269 | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| GEORGE F PUTZEK | | | | | | | | Month 1 Day 18 Year 68 | | | | 3:30 am | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | Cau | | 8/2/93 | | | | 7 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md. | | | |
| Germany | | USA. | | | | Montgomery | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | | | Holy Cross | | | | COAL MINER | | | | MINING | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| XXXXXX XXXX W. Va. | | | | ✓ | | Bridgeport | | | | MAIN ST. | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | Address | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | | | |
| JOHN PUTZEK UNKNOWN | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | |
| NO | | | | UNKNOWN | | LLOYD PUTZEK | | LAUREL MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 5329 RENAL INFARCTION, BILATERAL | | | | | | | | | | 14 hours | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE AND INFER. VENA CAVA RENAL VEINS | | | | | | | | | | 14 hours | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5470 (b) THROMBOPHLEBITIS, FEMORAL, ILIAC VEINS, BILATERAL | | | | | | | | | | 7 DAYS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) STATUS POST-SUBTOTAL GASTRECTOMY | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| BILATERAL RENAL INSUFFICIENCY, CHRONIC, DUE TO GOUT OR ARTERIO-SCLEROSIS | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 11/16/68 1/17/68 | | CHRONIC DUODENAL ULCER 2 THROMB. ILIAC, FEMORAL | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 27 DEC., 1967, to 18 JAN., 1968, that (I) (we) last saw the deceased alive on 18 JAN. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| J. RICHARD COMPTON M.D. | | | | | | | | 18 JAN 1968 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | |
| J. RICHARD COMPTON | | | | 612 MAIN ST., LAUREL, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| BURIAL | | JAN 21, 1968 | | SIMPSON CEM | | SIMPSON, WEST VA. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| W. W. C. Lambert Co. INC. | | | | | | DATE JAN 23 1968 | | Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|--|--|--|--------------------------|---|---|---|--|--|
| 01274 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01270 | | |
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M |
| JOHN | | | J. | | QUEEN JR. | JANUARY 14 - 1968 | | 11:20 A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| MALE | | WHITE | | Feb-12-1920 | | 47 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Charles Co. Md. | | U.S.A. | | | | Montg. Co. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Selma Park | | 1922 - Long Br. Park Day Government Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | Montg. | | Selma Park | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Same as #11 |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| John J. | | | | | Queen Sr. | Not known. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 1922 - Address | |
| YES | | | 214-16-7085 | | Mrs. Eliz. J. Queen | | Long Br. Park Day Selma | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Anoxia | | | | | | | | |
| 1621 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) Cerebral Metastasis | | | | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) Bronchiogenic Carcinoma | | | | | | | | 2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 1621 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1967, to Jan 13, 1968, that (I) (we) last saw the deceased alive on Jan 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| Edward J. Richards M.D. | | | | | | | | 1-14-68 |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| | | | | 10110 Georgia Ave. Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | Jan-17-1968 | | Baltimore National | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Arthur Walters | | 254 Carroll St. | | Charles Judge | | | | |
| | | DATE | | JAN 18 1968 | | | | |

01330

01330

01330



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01275 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01271 | | | |
|---|--|---|--------------------------|---|---|---|--|--|----------|--|------|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Willard Jay Radler | | | | | | Month Day Year
January 19 1968 | | | 7:00 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | 4 October 1922 | | 45 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| New Jersey | | USA | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| Bethesda | | The Clinical Center, NIH | | Manager | | Instrument Co. | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| New Jersey | | | | Colonia | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 155 Jeffery Road | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| Gutav Radler | | | | | | Frances Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| No | | | 140-18-9911 | | The Medical Record Address
The Clinical Center, Bethesda, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal and Respiratory failure</u>
<u>3960</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>410x</u>
(b) <u>Rheumatic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 Days</u>
<u>30 Years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<u>Uremia (5 days)</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 1/9/68 | | Mitral and Aortic Valve Disease | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>7 January, 1968</u> , to <u>19 Jan.</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>19 January</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Rudolf N. Staroscik</u> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>20 January 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Rudolf N. Staroscik, M.D.</u> | | | | | | 22e. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| BURIAL | | JAN. 24, 1968 | | HAZELWOOD CEMETERY | | RAHWAY | | N.J. | | | |
| 24. FUNERAL DIRECTOR
<u>Demond J. Gosselin</u> | | | | | | 660 NEW DOVER RD
COLONIA, N.J. | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 24 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|------------------|--|--|--|---|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Saca Bailey Reading</i> | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>1</i> Day <i>13</i> Year <i>1968</i> | | | 2b. HOUR <i>7:15</i> AM | | | |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>3-25-87</i> | 6. AGE (In years last birthday) <i>80</i> YRS. | IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> | IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i> | 2c. DATE PRONOUNCED DEAD Month <i>1</i> Day <i>13</i> Year <i>1968</i> | | 2d. HOUR <i>7:15</i> AM | |
| 7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Dubuchan</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i> | | | 13b. COUNTY <i>WASH. DC</i> | | 13c. CITY OR TOWN <i>WASH. DC</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <i>3368 Stuyvesant Pl. N.W.</i> | | |
| 14. FATHER'S NAME First <i>Winford</i> Middle <i>Bailey</i> Last <i>Lucy</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Day</i> Middle <i>Day</i> Last <i>Day</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | | 16b. SOCIAL SECURITY NO. <i>NO</i> | | 17. INFORMANT <i>Husband - Steele - Same</i> | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Contract's Fracture of Rt Hip.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cardiovascular Disease.</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>48 hr.</i>
<i>4 days.</i>
<i>years.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>9040</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year <i>Jan 9 1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fall at home causing fracture of Hip.</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>3368 Stuyvesant Pl.</i> City or Town <i>Washington.</i> County <i>DC</i> State <i>DC</i> | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Jan 13, 1968</i> | | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/15/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Frankfort Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Frankfort, Ky.</i> | | | |
| 24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons</i> | | | | ADDRESS <i>5130 Wisc. Ave. N.W. Wash DC</i> | | 25a. REC'D BY REGISTRAR <i>JAN 18 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

01510

WORLD TO BAPTIST CONVENTION

01510

WORLD TO BAPTIST CONVENTION

Religion

1

World to Baptist Convention

World to Baptist Convention

World to Baptist Convention

1

John A. Bell

1953

World to Baptist Convention

World to Baptist Convention

World to Baptist Convention

World to Baptist Convention

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|-----------------------------------|---------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
<i>Belle</i> | | | Middle
<i>Teresa</i> | | | Last
<i>Reid</i> | | | 2a. DATE OF DEATH
Month
<i>January</i> Day
<i>20</i> Year
<i>1968</i> | | | 2b. HOUR
<i>11 P M</i> | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>Caucasian</i> | | | 5. DATE OF BIRTH
<i>April 20, 1885</i> | | | 6. AGE (In years last birthday)
<i>82</i> YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Lockport, New York</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Belle Vista Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Cashier</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Life Insurance Co.</i> | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>Athania 13607 XXXXX Street</i> | | | | | |
| 14. FATHER'S NAME
First
<i>John</i> | | | Middle
<i>Reid</i> | | | Last
<i>Reid</i> | | | 15. MOTHER'S MAIDEN NAME
First
<i>Mary Ann</i> | | | Middle
<i>O'Neill</i> | | | Last
<i>O'Neill</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown
<i>No</i> | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>Yes</i> | | | 17. INFORMANT
<i>Francis R. Dowling Silver Spring, Md.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Pneumonia</i> | | | | | | | | | | | | <i>2 Days</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332X</i> | | | | | | | | | | | | | | | | | |
| (b) <i>Cerebral Thrombosis</i> | | | | | | | | | | | | <i>1 Mo</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Senile Psychosis</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>67</i> , to <i>Jan. 20, 1968</i> ; that (I) (we) last saw the deceased alive on <i>Jan. 20, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Harold Hedges MD</i> | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>1/21/68</i> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Harold Hedges</i> | | | 22e. ADDRESS
<i>5415 Conn Ave NW DC</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>Jan. 23, 1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Silver Spring, Maryland</i> | | | | | | | | |
| 23e. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | ADDRESS
<i>8434 Georgia Avenue Silver Spring, Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>JAN 25 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01278

01274

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|--|----------------------|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(Type or Print) WILLIAM CURTIS REISINGER | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 28 Year 1968 | | | 2b. HOUR 12:30 A.M. | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 6-16-22 | 6. AGE (In years last birthday) 45 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month 1 Day 28 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED - NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN ADELPHI | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 7914 WEST PARK DR. | |
| 14. FATHER'S NAME First CURTIS Middle REISINGER Last BEULAH | | | 15. MOTHER'S MAIDEN NAME First MORSE Middle AS ABOVE Last REISINGER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO. 1940-1960 178-24-8085 | | 17. INFORMANT ADDRESS MRS. DOROTHY REISINGER - WIFE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency, Acute.
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Arterio Sclerosis -
DUE TO, OR AS A CONSEQUENCE OF
(c) 4129
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 Mtn.
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John S. Ball | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED Jan-28, 1968 | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-31-68 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) Arlington, Va. | | (County) (State) |
| 24. FUNERAL DIRECTOR Francis J. Collins | | | | ADDRESS 3821 14th St., N.W. Wash DC | | 25a. REC'D BY REGISTRAR JAN 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

27510

22

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01279 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01275

| | | | | | |
|--|--------------------------|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <u>Leroy</u> First Middle Last <u>Rich</u> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>1</u> Day <u>17</u> Year <u>1968</u> | | 2b. HOUR <u>9A</u> M. |
| 3. SEX <u>M</u> | 4. RACE <u>Negro</u> | 5. DATE OF BIRTH <u>3-15-13</u> | 6. AGE (In years and birth day) <u>54</u> YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | IF UNDER 24 HRS. HOURS _____ MIN. _____ |
| 7a. BIRTHPLACE (State or foreign country) <u>N. Caro.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Bus Driver</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.C.</u> | | 13b. COUNTY <u>WASH. D.C.</u> | 13c. CITY OR TOWN <u>WASH. D.C.</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <u>646 Meton ST. N.W.</u> |
| 14. FATHER'S NAME First <u>George</u> Middle _____ Last _____ | | | 15. MOTHER'S MAIDEN NAME First <u>Lizzie</u> Middle <u>Rich</u> Last _____ | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>1941-1943</u> | | 16b. SOCIAL SECURITY NO. _____ | | 17. INFORMANT <u>Wife</u> ADDRESS _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | | | <u>20 min</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Vascular Disease</u> | | | | | <u>years</u> |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u> | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____ | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____ | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <u>Jan 17/1968</u> | |
| EXAMINER'S NAME (Type) _____ | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ADDRESS (Street, city, town, or county) _____ | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) _____ | 23b. DATE <u>1/19/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Fayetteville N.C.</u> | |
| 24. FUNERAL DIRECTOR <u>John S. Ball</u> | | ADDRESS <u>4804 Gales NW</u> | | 25a. REC'D BY REGISTRAR <u>JAN 24 1968</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

01510

01510

RECEIVED

100-100



Psychosocial N.Y.

Johnson University

1/10/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|---|---|--|------------------------------------|--|--|--|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Guila First Richard Middle son Last | | | | | | 2a. DATE OF DEATH Month Jan Day 30 Year 1968 | | | 2b. HOUR 10:30 M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Jan 30, 1884 | | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Tenn | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7301 Marbury Rd | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Fla | | | 13b. COUNTY Broward | | 13c. CITY OR TOWN Hollywood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3215 Calle Sarge | | | |
| 14. FATHER'S NAME First Abner G. Middle Rickett Last | | | | 15. MOTHER'S MAIDEN NAME First Bena Middle Cole Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 372-05540 | | 17. INFORMANT Heleen Price Address 7301 Marbury Rd | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
4339
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Thrombosis & Hemiplegia
DUE TO, OR AS A CONSEQUENCE OF
(c) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Hours
60 Pkrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
332X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 20, 1967 , to Jan 30, 1968 , that (I) (we) last saw the deceased alive on Jan 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE E. Herbert Bauersfeld M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/30/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) E. Herbert Bauersfeld | | | | | | 22e. ADDRESS 2401 Calvert St N W | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 2-1-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Grandlawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Detroit, Michigan | | | |
| 24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | 25a. REC'D BY REGISTRAR FEB 2 1968 DATE | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



01281

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01277

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR | |
| IRA | | ROBERT | | RIIBNER | | | | Jan. 5, 1968 | | 7:30 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| Male | White | Dec. 21, 1963 | | 4 YRS. | | MONTHS DAYS | | HOURS MIN. | | January 5, 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | 2d. HOUR | |
| Maryland | | USA | | | | Montgomery | | | | 7:30 A.M. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Takoma Park | | Wash. Sanitarium | | Infant | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | MONTGOMERY | | TAK. PK. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8606 Garland Avenue | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Herman | | Riibner | | Rona | | Casel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No | | none | | Rona Casel, 8606 Garland Ave. Tak Pk, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Encephalitis</u> | | | | | | | | | | 36 hr. | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Varicella</u> | | | | | | | | | | 5 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? | | | | | | | | | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| CAUSE OF DEATH | | HOUR A.M. P.M. | | 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | | | | | | | 1-6-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Jan 7, 1968 | | Nat'l. Mem. Park | | Falls Church, Va. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Goldberg Funeral Home | | 4217 9th Street N.W. | | JAN 10 1968 | | Charles Judge | | | | | |

1

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

1996

01282

CERTIFICATE OF DEATH

01278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4314 Chestnut Street | | e. STREET ADDRESS
4314 Chestnut Street | |
| 3. NAME OF DECEASED (Type or print)
First HOWARD A. Middle RINE Last | | 4. DATE OF DEATH
Month JAN Day 1 Year 1968 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar. 13, 1873 |
| 9. AGE (In years last birthday)
94 yrs. | | IF UNDER 1 YEAR
Months Days IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-44-5894 | |
| 17. INFORMANT
wife | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Collapse
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221
(b) Arteriosclerotic Cardiovascular Disease Years
DUE TO
(c) Generalized Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Benign Prostatic Hypertrophy and Uremia | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 77 , 19 62 , to 77 , 19 62 , that (I) (we) last saw the deceased alive on Dec 22 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ronald Schreiber | | 22b. DATE SIGNED
1/1/68 | |
| 22c. PHYSICIAN'S NAME (Type) RONALD SCHREIBER | | 22d. ADDRESS
11125 ROCKVILLE PIKE, ROCKVILLE, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
1-4-68 | 23c. NAME OF CEMETERY OR CREMATORY
Rockville Cemetery | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
DATE JAN 11 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

01885

RECEIVED 10 10 1961

01885

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF VESSEL | | 2. TYPE OF VESSEL | | 3. HOME PORT | |
| 4. DATE OF DEPARTURE | | 5. TIME OF DEPARTURE | | 6. DESTINATION | |
| 7. NAME OF CAPTAIN | | 8. NAME OF MASTER | | 9. NAME OF FIRST OFFICER | |
| 10. NAME OF SECOND OFFICER | | 11. NAME OF THIRD OFFICER | | 12. NAME OF FOURTH OFFICER | |
| 13. NAME OF FIFTH OFFICER | | 14. NAME OF SIXTH OFFICER | | 15. NAME OF SEVENTH OFFICER | |
| 16. NAME OF EIGHTH OFFICER | | 17. NAME OF NINTH OFFICER | | 18. NAME OF TENTH OFFICER | |
| 19. NAME OF ELEVENTH OFFICER | | 20. NAME OF TWELFTH OFFICER | | 21. NAME OF THIRTEENTH OFFICER | |
| 22. NAME OF FOURTEENTH OFFICER | | 23. NAME OF FIFTEENTH OFFICER | | 24. NAME OF SIXTEENTH OFFICER | |
| 25. NAME OF SEVENTEENTH OFFICER | | 26. NAME OF EIGHTEENTH OFFICER | | 27. NAME OF NINETEENTH OFFICER | |
| 28. NAME OF TWENTIETH OFFICER | | 29. NAME OF TWENTY-FIRST OFFICER | | 30. NAME OF TWENTY-SECOND OFFICER | |
| 31. NAME OF TWENTY-THIRD OFFICER | | 32. NAME OF TWENTY-FOURTH OFFICER | | 33. NAME OF TWENTY-FIFTH OFFICER | |
| 34. NAME OF TWENTY-SIXTH OFFICER | | 35. NAME OF TWENTY-SEVENTH OFFICER | | 36. NAME OF TWENTY-EIGHTH OFFICER | |
| 37. NAME OF TWENTY-NINTH OFFICER | | 38. NAME OF THIRTIETH OFFICER | | 39. NAME OF THIRTY-FIRST OFFICER | |
| 40. NAME OF THIRTY-SECOND OFFICER | | 41. NAME OF THIRTY-THIRD OFFICER | | 42. NAME OF THIRTY-FOURTH OFFICER | |
| 43. NAME OF THIRTY-FIFTH OFFICER | | 44. NAME OF THIRTY-SIXTH OFFICER | | 45. NAME OF THIRTY-SEVENTH OFFICER | |
| 46. NAME OF THIRTY-EIGHTH OFFICER | | 47. NAME OF THIRTY-NINTH OFFICER | | 48. NAME OF FORTY OFFICER | |
| 49. NAME OF FORTY-FIRST OFFICER | | 50. NAME OF FORTY-SECOND OFFICER | | 51. NAME OF FORTY-THIRD OFFICER | |
| 52. NAME OF FORTY-FOURTH OFFICER | | 53. NAME OF FORTY-FIFTH OFFICER | | 54. NAME OF FORTY-SIXTH OFFICER | |
| 55. NAME OF FORTY-SEVENTH OFFICER | | 56. NAME OF FORTY-EIGHTH OFFICER | | 57. NAME OF FORTY-NINTH OFFICER | |
| 58. NAME OF FIFTY OFFICER | | 59. NAME OF FIFTY-FIRST OFFICER | | 60. NAME OF FIFTY-SECOND OFFICER | |
| 61. NAME OF FIFTY-THIRD OFFICER | | 62. NAME OF FIFTY-FOURTH OFFICER | | 63. NAME OF FIFTY-FIFTH OFFICER | |
| 64. NAME OF FIFTY-SIXTH OFFICER | | 65. NAME OF FIFTY-SEVENTH OFFICER | | 66. NAME OF FIFTY-EIGHTH OFFICER | |
| 67. NAME OF FIFTY-NINTH OFFICER | | 68. NAME OF SIXTY OFFICER | | 69. NAME OF SIXTY-FIRST OFFICER | |
| 70. NAME OF SIXTY-SECOND OFFICER | | 71. NAME OF SIXTY-THIRD OFFICER | | 72. NAME OF SIXTY-FOURTH OFFICER | |
| 73. NAME OF SIXTY-FIFTH OFFICER | | 74. NAME OF SIXTY-SIXTH OFFICER | | 75. NAME OF SIXTY-SEVENTH OFFICER | |
| 76. NAME OF SIXTY-EIGHTH OFFICER | | 77. NAME OF SIXTY-NINTH OFFICER | | 78. NAME OF SEVENTY OFFICER | |
| 79. NAME OF SEVENTY-FIRST OFFICER | | 80. NAME OF SEVENTY-SECOND OFFICER | | 81. NAME OF SEVENTY-THIRD OFFICER | |
| 82. NAME OF SEVENTY-FOURTH OFFICER | | 83. NAME OF SEVENTY-FIFTH OFFICER | | 84. NAME OF SEVENTY-SIXTH OFFICER | |
| 85. NAME OF SEVENTY-SEVENTH OFFICER | | 86. NAME OF SEVENTY-EIGHTH OFFICER | | 87. NAME OF SEVENTY-NINTH OFFICER | |
| 88. NAME OF EIGHTY OFFICER | | 89. NAME OF EIGHTY-FIRST OFFICER | | 90. NAME OF EIGHTY-SECOND OFFICER | |
| 91. NAME OF EIGHTY-THIRD OFFICER | | 92. NAME OF EIGHTY-FOURTH OFFICER | | 93. NAME OF EIGHTY-FIFTH OFFICER | |
| 94. NAME OF EIGHTY-SIXTH OFFICER | | 95. NAME OF EIGHTY-SEVENTH OFFICER | | 96. NAME OF EIGHTY-EIGHTH OFFICER | |
| 97. NAME OF EIGHTY-NINTH OFFICER | | 98. NAME OF NINETY OFFICER | | 99. NAME OF NINETY-FIRST OFFICER | |
| 100. NAME OF NINETY-SECOND OFFICER | | 101. NAME OF NINETY-THIRD OFFICER | | 102. NAME OF NINETY-FOURTH OFFICER | |
| 103. NAME OF NINETY-FIFTH OFFICER | | 104. NAME OF NINETY-SIXTH OFFICER | | 105. NAME OF NINETY-SEVENTH OFFICER | |
| 106. NAME OF NINETY-EIGHTH OFFICER | | 107. NAME OF NINETY-NINTH OFFICER | | 108. NAME OF HUNDRED OFFICER | |
| 109. NAME OF HUNDRED-FIRST OFFICER | | 110. NAME OF HUNDRED-SECOND OFFICER | | 111. NAME OF HUNDRED-THIRD OFFICER | |
| 112. NAME OF HUNDRED-FOURTH OFFICER | | 113. NAME OF HUNDRED-FIFTH OFFICER | | 114. NAME OF HUNDRED-SIXTH OFFICER | |
| 115. NAME OF HUNDRED-SEVENTH OFFICER | | 116. NAME OF HUNDRED-EIGHTH OFFICER | | 117. NAME OF HUNDRED-NINTH OFFICER | |
| 118. NAME OF HUNDRED-TENTH OFFICER | | 119. NAME OF HUNDRED-ELEVENTH OFFICER | | 120. NAME OF HUNDRED-TWELTH OFFICER | |
| 121. NAME OF HUNDRED-THIRTEENTH OFFICER | | 122. NAME OF HUNDRED-FOURTEENTH OFFICER | | 123. NAME OF HUNDRED-FIFTEENTH OFFICER | |
| 124. NAME OF HUNDRED-SIXTEENTH OFFICER | | 125. NAME OF HUNDRED-SEVENTEENTH OFFICER | | 126. NAME OF HUNDRED-EIGHTEENTH OFFICER | |
| 127. NAME OF HUNDRED-NINETEENTH OFFICER | | 128. NAME OF HUNDRED-TWENTY OFFICER | | 129. NAME OF HUNDRED-TWENTY-FIRST OFFICER | |
| 130. NAME OF HUNDRED-TWENTY-SECOND OFFICER | | 131. NAME OF HUNDRED-TWENTY-THIRD OFFICER | | 132. NAME OF HUNDRED-TWENTY-FOURTH OFFICER | |
| 133. NAME OF HUNDRED-TWENTY-FIFTH OFFICER | | 134. NAME OF HUNDRED-TWENTY-SIXTH OFFICER | | 135. NAME OF HUNDRED-TWENTY-SEVENTH OFFICER | |
| 136. NAME OF HUNDRED-TWENTY-EIGHTH OFFICER | | 137. NAME OF HUNDRED-TWENTY-NINTH OFFICER | | 138. NAME OF HUNDRED-THIRTY OFFICER | |
| 139. NAME OF HUNDRED-THIRTY-FIRST OFFICER | | 140. NAME OF HUNDRED-THIRTY-SECOND OFFICER | | 141. NAME OF HUNDRED-THIRTY-THIRD OFFICER | |
| 142. NAME OF HUNDRED-THIRTY-FOURTH OFFICER | | 143. NAME OF HUNDRED-THIRTY-FIFTH OFFICER | | 144. NAME OF HUNDRED-THIRTY-SIXTH OFFICER | |
| 145. NAME OF HUNDRED-THIRTY-SEVENTH OFFICER | | 146. NAME OF HUNDRED-THIRTY-EIGHTH OFFICER | | 147. NAME OF HUNDRED-THIRTY-NINTH OFFICER | |
| 148. NAME OF HUNDRED-FORTY OFFICER | | 149. NAME OF HUNDRED-FORTY-FIRST OFFICER | | 150. NAME OF HUNDRED-FORTY-SECOND OFFICER | |
| 151. NAME OF HUNDRED-FORTY-THIRD OFFICER | | 152. NAME OF HUNDRED-FORTY-FOURTH OFFICER | | 153. NAME OF HUNDRED-FORTY-FIFTH OFFICER | |
| 154. NAME OF HUNDRED-FORTY-SIXTH OFFICER | | 155. NAME OF HUNDRED-FORTY-SEVENTH OFFICER | | 156. NAME OF HUNDRED-FORTY-EIGHTH OFFICER | |
| 157. NAME OF HUNDRED-FORTY-NINTH OFFICER | | 158. NAME OF HUNDRED-FIFTY OFFICER | | 159. NAME OF HUNDRED-FIFTY-FIRST OFFICER | |
| 160. NAME OF HUNDRED-FIFTY-SECOND OFFICER | | 161. NAME OF HUNDRED-FIFTY-THIRD OFFICER | | 162. NAME OF HUNDRED-FIFTY-FOURTH OFFICER | |
| 163. NAME OF HUNDRED-FIFTY-FIFTH OFFICER | | 164. NAME OF HUNDRED-FIFTY-SIXTH OFFICER | | 165. NAME OF HUNDRED-FIFTY-SEVENTH OFFICER | |
| 166. NAME OF HUNDRED-FIFTY-EIGHTH OFFICER | | 167. NAME OF HUNDRED-FIFTY-NINTH OFFICER | | 168. NAME OF HUNDRED-SIXTY OFFICER | |
| 169. NAME OF HUNDRED-SIXTY-FIRST OFFICER | | 170. NAME OF HUNDRED-SIXTY-SECOND OFFICER | | 171. NAME OF HUNDRED-SIXTY-THIRD OFFICER | |
| 172. NAME OF HUNDRED-SIXTY-FOURTH OFFICER | | 173. NAME OF HUNDRED-SIXTY-FIFTH OFFICER | | 174. NAME OF HUNDRED-SIXTY-SIXTH OFFICER | |
| 175. NAME OF HUNDRED-SIXTY-SEVENTH OFFICER | | 176. NAME OF HUNDRED-SIXTY-EIGHTH OFFICER | | 177. NAME OF HUNDRED-SIXTY-NINTH OFFICER | |
| 178. NAME OF HUNDRED-SEVENTY OFFICER | | 179. NAME OF HUNDRED-SEVENTY-FIRST OFFICER | | 180. NAME OF HUNDRED-SEVENTY-SECOND OFFICER | |
| 181. NAME OF HUNDRED-SEVENTY-THIRD OFFICER | | 182. NAME OF HUNDRED-SEVENTY-FOURTH OFFICER | | 183. NAME OF HUNDRED-SEVENTY-FIFTH OFFICER | |
| 184. NAME OF HUNDRED-SEVENTY-SIXTH OFFICER | | 185. NAME OF HUNDRED-SEVENTY-SEVENTH OFFICER | | 186. NAME OF HUNDRED-SEVENTY-EIGHTH OFFICER | |
| 187. NAME OF HUNDRED-SEVENTY-NINTH OFFICER | | 188. NAME OF HUNDRED-EIGHTY OFFICER | | 189. NAME OF HUNDRED-EIGHTY-FIRST OFFICER | |
| 190. NAME OF HUNDRED-EIGHTY-SECOND OFFICER | | 191. NAME OF HUNDRED-EIGHTY-THIRD OFFICER | | 192. NAME OF HUNDRED-EIGHTY-FOURTH OFFICER | |
| 193. NAME OF HUNDRED-EIGHTY-FIFTH OFFICER | | 194. NAME OF HUNDRED-EIGHTY-SIXTH OFFICER | | 195. NAME OF HUNDRED-EIGHTY-SEVENTH OFFICER | |
| 196. NAME OF HUNDRED-EIGHTY-EIGHTH OFFICER | | 197. NAME OF HUNDRED-EIGHTY-NINTH OFFICER | | 198. NAME OF HUNDRED-NINETY OFFICER | |
| 199. NAME OF HUNDRED-NINETY-FIRST OFFICER | | 200. NAME OF HUNDRED-NINETY-SECOND OFFICER | | 201. NAME OF HUNDRED-NINETY-THIRD OFFICER | |
| 202. NAME OF HUNDRED-NINETY-FOURTH OFFICER | | 203. NAME OF HUNDRED-NINETY-FIFTH OFFICER | | 204. NAME OF HUNDRED-NINETY-SIXTH OFFICER | |
| 205. NAME OF HUNDRED-NINETY-SEVENTH OFFICER | | 206. NAME OF HUNDRED-NINETY-EIGHTH OFFICER | | 207. NAME OF HUNDRED-NINETY-NINTH OFFICER | |
| 208. NAME OF HUNDRED | | 209. NAME OF HUNDRED | | 210. NAME OF HUNDRED | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

01283 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 10 & 11 Film 385 278 488 175
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01279

| | | | | | | | | |
|---|-------------------|---|---|--|-------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Mary Lee Ritter</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>Jan 29 1968</i> | | | 2b. HOUR <i>7:00 AM</i> | | |
| 3. SEX <i>fe.</i> | 4. RACE <i>W.</i> | 5. DATE OF BIRTH <i>1/13/95</i> | 6. AGE (In years last birthday) <i>73</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year <i>Jan 29 1968</i> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Indiana</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>on highway-Georgetown Rd.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Sales Lady</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Woodward</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Cherry Chase</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>4337 Cherry Chase</i> |
| 14. FATHER'S NAME <i>Harris Hastings</i> | | | 15. MOTHER'S MAIDEN NAME <i>Cora</i> | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | |
| 16a. SOCIAL SECURITY NO. <i>130-20-1246</i> | | | 17. INFORMANT <i>Boies Ritter</i> | | | ADDRESS <i>46-W. 7th St. Hingham, Pa.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>8147</i>
(b) <i>Trauma from Auto Accident.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>8124</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
<i>7 P.M. Jan 29 1968</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Struck by car</i> | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<i>Street</i> | | | 21f. LOCATION Street or R.F.D. No. <i>8600</i> City or Town <i>Georgetown Rd.</i> County <i>Bethesda</i> State <i>Montgomery Md.</i> | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>Jan 29, 1968</i> | | |
| EXAMINER'S NAME (Type) <i>JOHN G. BALL</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE <i>2-1-68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | |
| 23d. LOCATION (City or Town) <i>Rockville, Maryland</i> | | | 23e. (County) <i>Montgomery</i> | | | 23f. (State) <i>Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | | | 25a. REC'D BY REGISTRAR
DATE <i>FEB 2 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

01387

01387

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-3-10000)
FROM : SAC, NEW YORK (100-3-10000)
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|------------------------|--|--|--|--|--|--|--|
| 01284 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01280 | | | | | | | |
| 1. DECEASED-NAME (Type or print) Francis J. Rogers | | | | | | | | | | 2a. DATE OF DEATH Month Jan Day 28 Year 1968 | | | | | | | | | | 2b. HOUR 11 P M | | | | | | | |
| 3. SEX Male | | | | 4. RACE Cauc. | | | | 5. DATE OF BIRTH Oct. 26, 1878 | | | | 6. AGE (In years last birthday) 89 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Mass. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley N. H. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Doctor | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Wheaton | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER 2709 Weisman Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME First Joseph Middle Rogers Last | | | | | | 15. MOTHER'S MAIDEN NAME First Sara Middle Coyne Last | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service) WW I | | | | | | 16b. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Son Address Same as Item 13 Laurence A. Rogers | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271
(b) Pulmonary emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks
years | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
AS heart disease & generalized arteriosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1967 , to Jan 28, 1968 , that (I) (we) last saw the deceased alive on Jan 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE G. Bowditch Hunter, Jr. | | | | | | | | | | | | | | 22c. DATE SIGNED Jan 29, 1968 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) G. BOWDITCH HUNTER, Jr. | | | | | | | | | | | | | | 22e. ADDRESS 50 W. Edmonston Ave. Rockville, Maryland | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 2-2-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Northampton, Mass. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 2 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------|--|---|---|---|---|---|---|--|
| 01285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01281 | | | | | | | | | |
| 1. OCCASED-NAME
(Type or Print) <u>George P. Rohrman</u> | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>Jan.</u> Day <u>4</u> Year <u>1968</u> | | 2b. HOUR <u>4:25</u> M | |
| 3. SEX <u>M</u> | 4. RACE <u>W</u> | 5. DATE OF BIRTH <u>Dec. 20-1885</u> | 6. AGE (In years last birthday) <u>82</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month <u>Jan.</u> Day <u>4</u> Year <u>1967</u> | | 2d. HOUR <u>4</u> P.M. | |
| 7a. BIRTHPLACE (State or foreign country) <u>N.Y.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> | | Md. | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Accountant</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>102 Northbrook Lane</u> | |
| 14. FATHER'S NAME First <u>Fred</u> Middle <u>Rohrman</u> Last <u></u> | | | 15. MOTHER'S MAIDEN NAME First <u>Carrie</u> Middle <u>Fry</u> Last <u></u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. <u>678-70-7632</u> | | 17. INFORMANT <u>Mrs Mary J Rohrman</u> | | ADDRESS <u>Same as above</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>431.9</u>
(b) <u>cerebral arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hr.</u>
<u>years.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>331X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>Jan. 5, 1968</u> | | | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county) <u>MONTG. COUNTY</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>1/8/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>COLUMBIA GARDENS</u> | | 23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u> | | | |
| 24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SON, 5130 WIS. AVE. NW, WASHINGTON, D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>JAN 10 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

18310

18310

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

18310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01286 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01282 | |
|---|--|---|---------|---|----------------|---|----------------------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| KATHRYN | | | Rebecca | Roller | Jan - 8 - 1968 | | 2b. HOUR
11 45 AM |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 7 th 1879 | | 6. AGE (In years last birthday)
88 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Lebanon-Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bensington, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kensington Gardens Sanitarium | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Solomon | | 15. MOTHER'S MAIDEN NAME
McCauley | | 16. SOCIAL SECURITY NO.
578-50-8186 | | 17. INFORMANT
Virginia Maloney Washington, D. C. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
578-50-8186 | | 17. INFORMANT
Virginia Maloney Washington, D. C. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>334 X</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>334 X</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>334 X</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>334 X</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs
30 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1966, to Jan 8, 1968, that (I) (we) last saw the deceased alive on Jan 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | 22c. DATE SIGNED
1/8/68 | | 22d. ADDRESS
16 F Kreuzburg | | 22e. ADDRESS
7852 16 th St NW Wash D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Trans-burial | | 23b. DATE
Jan. 11, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Lancaster, Pennsylvania | |
| 23e. FUNERAL DIRECTOR
C. Glen Carter | | 23f. ADDRESS
8434 Georgia Ave. | | 23g. ADDRESS
Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | |
| 23e. FUNERAL DIRECTOR
C. Glen Carter | | 23f. ADDRESS
8434 Georgia Ave. | | 23g. ADDRESS
Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

222819

تاریخ: ۱۳۸۵/۰۵/۰۵

671-92-452

0104051-467814

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| 01287 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01283 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) <u>Albert</u> | | | | | | | | | | First Middle Last <u>ROSENDORN</u> | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>Jan</u> Day <u>1</u> Year <u>1968</u> | | | | | | | | | | 2b. HOUR <u>12:10</u> M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX <u>M.</u> | | | | | | | | | | 4. RACE <u>W.</u> | | | | | | | | | | 5. DATE OF BIRTH <u>OCT 15, 1901</u> | | | | | | | | | | 6. AGE (In years last birthday) <u>66</u> YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u> | | | | | | | | | | 7c. DATE PRONOUNCED DEAD Month <u>Jan</u> Day <u>1</u> Year <u>1968</u> | | | | | | | | | | 2d. HOUR <u>12:10</u> M | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <u>MD.</u> | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH <u>Montgomery</u> | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>5014 Battery Lane</u> | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Architect</u> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> | | | | | | | | | | 13b. COUNTY <u>MONTGOMERY</u> | | | | | | | | | | 13c. CITY OR TOWN <u>BETHESDA</u> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER <u>5014 BATTERY LANE</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last <u>Philip A. Rosendorn</u> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <u>Carrie F. Huber</u> | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | | | | | 16b. SOCIAL SECURITY NO. <u>408-32-2340</u> | | | | | | | | | | 17. INFORMANT <u>wife</u> ADDRESS <u>Same as Item 13.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pyelonephritis, acute</u>
<u>600x</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>urinary obstruction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>benign hyperplasia, prostate</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks -</u>
<u>months -</u>
<u>years.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>610x</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year <u>19</u> HOUR A.M. <u>0</u> P.M. <u>0</u> | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED <u>Jan 2, 1968</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | ADDRESS (Street, city, town, or county) <u>Bethesda, Md.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, <u>Cremation</u> | | | | | | | | | | 23b. DATE <u>3 Jan 1968</u> | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | | | | | | | | | 23d. LOCATION (City or Town) <u>Suitland</u> (County) <u>Pr. Geo</u> (State) <u>Md</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> | | | | | | | | | | ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>JAN 5 1968</u> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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MEDICAL EXAMINATION REPORT

10-10-1960

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REPORT OF MEDICAL EXAMINATION
DATE: 10-10-1960
TIME: 10:00 AM
PLACE: [illegible]
PATIENT: [illegible]
EXAMINER: [illegible]
FINDINGS: [illegible]
CONCLUSION: [illegible]
REMARKS: [illegible]
SIGNATURE: [illegible]
DATE: 10-10-1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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cleared with medical examiner

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|--|------------------|---|---|--|---|---|--|---|--|
| 01289 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01285 | | | |
| Item 8 Film G397 1/24/68 kk | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
SATURNINO ACHILLES SAGRARIO | | | 2a. DATE OF DEATH Month Day Year
JAN 4 1968 | | | 2b. HOUR
7 ⁴⁵ AM | | | |
| 3. SEX
MALE | 4. RACE
WHITE | | 5. DATE OF BIRTH
MAY 17, 1919 | | 6. AGE (In years last birthday)
48 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
FRANCE | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
FAIRLAND NURSING HOME 2101 FAIRLAND RD DIST GOV'T. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7809 TILBURY ST | |
| 14. FATHER'S NAME First Middle Last
Don Jose Felipe Sagrario | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Josephine Bellini | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
220-48-9813 | | 17. INFORMANT
Address
Germantown Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 485X Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
491X Cerebral Arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April, 1967, to Jan 4, 1968, that (I) (we) last saw the deceased alive on Dec 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Boris Rabkin | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 4, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
BORIS RABKIN | | 22e. ADDRESS
1019 Univ. Blvd E.S. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
1-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn | | 23d. LOCATION (City or Town) (County) (State)
Bladenburg Md | | | |
| 24. FUNERAL DIRECTOR
Burt B. Gartner | | ADDRESS
1019 Univ. Blvd E.S. | | 25a. REC'D BY REGISTRAR
JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01290
Item 23d Film G396 1/18/68 kk | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01286 | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| First Middle Last | | | | Month Day Year | | | | Hour Min. | | | |
| Anastasios (NMN) Sahlas | | | | January 5 1968 | | | | 4:55 A | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. UNDER 1 YEAR | | 7. UNDER 24 HRS. | |
| Male | | White | | 2 March 1938 | | 29 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Greece | | Greece | | | | Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | The Clinical Center, NIH | | Barber | | Service | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Sparta, Greece | | --- | | Sparta | | | | Palio-Panagia, Lakonia | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| First Middle Last | | First Middle Last | | No | | None | | The Medical Records, The Clinical Center, NIH | | Bethesda, Md. 20014 | |
| George Sahlas | | Pota Malouhu | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart Failure | | | | | | | | | | 24 hours | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Aortic and mitral valve disease | | | | | | | | | | 10 - 20 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Rheumatic Heart Disease | | | | | | | | | | 10 - 20 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | | |
| 410x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 1/28/68 | | Aortic & mitral valve disease | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2 December, 1967, to 5 January, 1968, that (X) (we) last saw the deceased alive on 5 January 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Lynn M. Peterson MD | | 5 January 1968 | | Lynn M. Peterson, MD | | The Clinical Center, National Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) | | | | | |
| BURIAL | | 1-18-1968 | | GUTHRIE HOSPITAL | | SPARTA GREECE | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE | | | | | |
| W.H. Chambers Co | | JAN 16 1968 | | Charles Judge | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (1A)
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01291 | | | | | 01287 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Sarah Elizabeth Sanders | | | | | January 3, 1968 | | | 9 A. M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | |
| Female | | Cau. | | Oct. 6, 1879 | | 88 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Springs | | 10601 Glen Haven Drive | | Housewife | | Domestic | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Montgomery | | Silver Springs | | | | 10601 Glen Haven Drive | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Alexander Murray | | | Sarah Ann ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 215-54-8698 | | Ann Robey, 10601 Glen Haven Drive, Silver Springs, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Generalized Arteriosclerosis | | | | | | | | Years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Senility, emaciation | | | | | | | | 5 Years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Uninary Tract Infection | | | | | | | | Months? | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1968, to Jan. 3, 1968, that (I) (we) lost saw the deceased alive on Jan. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Hugo G. Grazianim, M.D. | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANIM, D.D. | | | | | 22e. ADDRESS 10101 Georgia Avenue Silver Springs, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-5-68 | | St Pauls Cemetery | | Waldorf, Charles, Md. | | | |
| 24. FUNERAL DIRECTOR The Huntt Funeral Home, Waldorf, Md. | | | | | 25a. REC'D BY REGISTRAR JAN 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

01232

01232

January 3, 1955 P. A. Elizabeth Zambata

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01292

01288

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) <i>Edith Lyle Lankey</i> | | | 2a. DATE OF DEATH
Month <i>January</i> Day <i>8</i> Year <i>68</i> | | | 2b. HOUR
<i>4:45</i> M | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>July 19th 1887</i> | | 6. AGE (In years last birthday)
<i>80</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Kansas</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Sales Representative</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13c. CITY OR TOWN
<i>Westwood</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>5300 Westwood Ave.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>James William Whitaker</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Emma Maria Keene</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
<i>550-12-3640</i> | | 17. INFORMANT <i>Robert T. Hartman</i> Address
<i>5001 Belknap Ave - N. Arlington - D.C.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral vascular thrombosis</i>
<i>4339</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cerebral arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized arteriosclerosis</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 DAY</i>
<i>2 YRS.</i>
<i>10 YRS.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>332x</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , 19____, to <i>1/8/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>1/7/68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Henry C. Scrizzo</i> M.D. | | | | 22c. DATE SIGNED
<i>1/8/68</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Dr. Henry C. Scrizzo</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Removal</i> | | 23b. DATE
<i>1-11-1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gettysburg Nat'l Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Gettysburg, Pa.</i> | |
| 24. FUNERAL DIRECTOR
<i>Joseph Gawler & Sons, Inc.</i> | | | | 25a. REC'D BY REGISTRAR
<i>JAN 15 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 01293 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01289 | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
HERBERT M. SAUBER | | | | | | | | | | 2a. DATE OF DEATH
Jan Month 9 Day 1968 Year | | | | | | | | | | 2b. HOUR
330 P M | | | | | | | | | | | | | | |
| 3. SEX
Male | | | | | 4. RACE
White | | | | | 5. DATE OF BIRTH
5-19-1897 | | | | | 6. AGE (In years lost birthday)
70 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | | IF UNDER 2 HRS.
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Chevy Chase Nursing Home | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Floor St | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Washington D.C. | | | | | 13c. CITY OR TOWN
City | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
4201 Cathedral Ave. N.W. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Adolph Sauber | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Graff | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address
Julius M. Sauber (Bro.) 1314 EYE St. N.W. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410.9 Myocardial Failure
DUE TO, OR AS A CONSEQUENCE OF
Coronary occlusion
(b) DUE TO, OR AS A CONSEQUENCE OF
Arteriosclerosis & Coronary Art. Dis.
(c) 10 + years
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate 1 or 2 min. prior | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 Nephritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, to Jan. 9, 1968, that (I) (we) lost saw the deceased alive on Jan. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Paul A. Lichtman MD | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
Jan. 9, 1968 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
PAUL A. LICHTMAN M.D. | | | | | 22e. ADDRESS
4201 Cathedral Ave., N.W. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
1-11-68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Adas Israel Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
B. Danzansky & Sons | | | | | ADDRESS
3501-14th St. N.W. Washington D.C. 20010 | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
O'Connell, Judge | | | | | | | | | | | | | | | | | | | |

02519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01294 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01290 | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|-----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Anna Mary Sch Leather</i> | | | | 2a. DATE OF DEATH Month <i>Jan</i> Day <i>2</i> Year <i>68</i> | | | | 2b. HOUR <i>9:28</i> AM | | | | | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>FEB 28 - 1882</i> | | | | 6. AGE (In years last birthday) <i>85</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>McDonnell Co - Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH <i>Montgomery Co.</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>CARNAHAN - ALBANY AVE.</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY <i>Wash., D.C.</i> | | 13c. CITY OR TOWN <i>Wash., D.C.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>407 Whittier St., N. W.</i> | | | | | |
| 14. FATHER'S NAME First <i>William Henry</i> Middle <i>Butler</i> Last <i>Butler</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Christina</i> Middle <i>Spellman</i> Last <i>Spellman</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) <i>No</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <i>577-01-3268</i> | | 17. INFORMANT <i>Mrs. Wm. W. McCracken</i> Address <i>6007 87th Ave. New Carrollton, Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Anginal seizure</i>
<i>412.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Coronary atherosclerosis, congestive</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Chronic arteriosclerosis</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
<i>Days</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/1/65</i> , to <i>1/29/68</i> , that (I) (we) last saw the deceased alive on <i>1/29/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Chas H. Wolotton, M.D.</i> | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>Jan. 29, 1968</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Chas H. Wolotton</i> | | | | 22e. ADDRESS <i>831 University Blvd. East. Silver Spring</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Feb. 1, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l. Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Arlington, Va.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>C. Glen Carter</i> | | | | ADDRESS <i>8434 Georgia Ave. Warner E. Humphrey, Inc. Silver Spring, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>FEB 2 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

01330

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01295

CERTIFICATE OF DEATH

01291

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) CAROLINE O. SCHLESINGER | | | 2a. DATE OF DEATH
Month JAN Day 24 Year 68 | | | 2b. HOUR
12:47 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
5/3/1894 | | 6. AGE (In years last birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SUBURBAN | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6803 BRENNAN LANE | |
| 14. FATHER'S NAME
First GUSTAV Middle OPPENHEIMER Last SIMON | | | 15. MOTHER'S MAIDEN NAME
First Julia Middle Simon Last SIMON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO | | 16b. SOCIAL SECURITY NO.
382-22-033B | | 17. INFORMANT
JEAN KONIGSBERG | | Address
See Item 13a-e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
420.7 | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. — P.M. — Month — Day 19 Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
— | | | |
| 21d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
— | | 21f. LOCATION Street or R.F.D. No. — City or Town — County — State — | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1952 , 19 — , to January , 19 68 , that (I) did saw the deceased alive on 1/18/68 , and that in (my) own opinion death occurred on the date and hour and from the cause stated above, (I) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
George C. Buchanan | | | | 22c. DATE SIGNED
1/24/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
GEORGE C. BUCHANAN | | | | 22e. ADDRESS
2001 Eye St. N.W. Washington, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-25-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Wash. Hebrew Congregation | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | | | 25a. REC'D BY REGISTRAR
JAN 31 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

Released by Medical Examiner - Montgomery - 1/24/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

015210

RECEIVED AT THE DEPT.

015210

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 01296 CERTIFICATE OF DEATH 01292 | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
John NMN Schmidt | | | | | | 2a. DATE OF DEATH
Month Day Year
January 15 1968 | | | 2b. HOUR
9:45 PM | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
12-9-94 | | | 6. AGE (In years last birthday)
73 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7. UNDER 24 HRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Penna | | 7b. CITIZEN OF WHAT COUNTRY?
Amer. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San. + Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Baker | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3600 Powder Mill Road | | |
| 14. FATHER'S NAME
First Middle Last
Philip Schmidt | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret Cornelius | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Med. records - W.S. Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
433.9 IMMEDIATE CAUSE (a) <u>Bronchopneumonia, acute</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cerebral thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
7 years | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332x | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 1965, to Jan 15, 1968, that (I) (we) last saw the deceased alive on Jan 15, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Welford D. Meyers M.D. | | | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
1-15-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Welford D. Meyers M.D. | | | | | | 22e. ADDRESS
8323 Haddon Dr Takoma Park Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
Jan 18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Takoma Park Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Takoma Park Montgomery Md | | | | |
| 24. FUNERAL DIRECTOR
Walter Wilfong Washington D.C. 20012 | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

01382

REPUBLIC OF DENMARK

01382

REPUBLIC OF DENMARK

REPUBLIC OF DENMARK
MINISTRY OF FOREIGN AFFAIRS
Copenhagen

16
1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01297

01293

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. LENGTH OF STAY IN 1b
31 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3815 Woodbine Street | | d. STREET ADDRESS
3815 Woodbine Street | |
| 3. NAME OF DECEASED (Type or print)
First FREDERICK Middle JOSEPH Last SCHMITT | | 4. DATE OF DEATH
Month JAN Day 2 Year 1968 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 6, 1900 |
| 9. AGE (In years last birthday) yrs.
67 | | 10. IF UNDER 1 YEAR
Months 6 Days 15 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (County & State, or foreign country)
Michigan | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Frederick J. Schmitt, Sr. | | 14. MOTHER'S MAIDEN NAME
Pauline Schellhamer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
WW I | |
| 17. INFORMANT
Wife | | Address
Maude A. Schmitt Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, lobes R.L.L.
DUE TO (b) Cerebral Thrombosis
DUE TO (c) Paralysis, hemiplegia
INTERVAL BETWEEN ONSET AND DEATH
6 days
7 years
7 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
332X | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March , 19 66 , to Jan , 19 68 , that (I) (we) last saw the deceased alive on Jan 2 , 19 68 , and that death occurred at 8:15 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Robert G. Taylor | | 22b. DATE SIGNED
Jan 2, 1968 | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT G. TAYLOR | | 22d. ADDRESS
Washington Clinic Washington DC. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
1-5-68 | 23c. NAME OF CEMETERY OR CREMATORY
Acacia Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Birmingham, Michigan |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
JAN 11 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | |

01303

ESTIMATE OF DEATH

01303

ESTIMATE OF DEATH

ESTIMATE OF DEATH

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ESTIMATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01295

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01294

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|--|----------|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | Month | | Day | | Year | | 2b. HOUR | | | |
| David | | | | | | Scull | | ESTIMATED | | Jan | | 23 | | 1968 | | 1:15 P M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | Month | | Day | | Year | | | |
| Male | W | 9/16/1917 | | 50 YRS | | MONTHS | | DAYS | | Jan | | 23 | | 1968 | | 1:15 P M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | | | Md. | | | |
| Penna. | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Bethesda. | | Suburban | | County Councilman. | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | | | |
| Md. | | Montgomery | | Silver Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9315 Greyrock Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | | | |
| Marshall | | | | | | Scull | | Anne | | | | | | Johnson. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | World War II | | YES | | Wife - Elizabeth Scull | | 515 Greyrock Rd. Silver Spring, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary thrombosis, acute | | | | | | | | | | | | | | | | Sudden. | | | |
| 410.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | years. | | | |
| (b) coronary arteriosclerosis | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | John G. Ball | | | | M.D. | | | | 22b. DATE SIGNED | | | | Jan. 23, 1968 | | | |
| EXAMINER'S NAME (Type) | | | | John G. Ball | | | | | | | | | | | | | | | |
| | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Cremation | | | | Jan. 24, 1968 | | | | Fort Lincoln Crematory | | | | Prince George Co., Md. | | | | | | | |
| Funeral Director | | | | Glen Carter | | | | 8434 Georgia Avenue | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. | | | | Silver Spring, Md. | | | | | | | | DATE JAN 30 1968 | | | | Charles Judge | | | |

18310

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

18310

CONFIDENTIAL - SECURITY MATTER

CONFIDENTIAL - SECURITY MATTER

CONFIDENTIAL - SECURITY MATTER

CONFIDENTIAL - SECURITY MATTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01299 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01295 | |
|--|------------------------------|--|--|---|---------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR |
| MINNIE | | | | SHEITELMAN | 1 | Month 4 Day 1968 Year | 11:05 |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. HOURS MIN. |
| Female | White | | 1-5-81 | | 86 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Russia | USA | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Wheaton, Md. | | Univ. Nursing Home 901 Arcola Ave. | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | Pr. Georges | | Hyatts. | | 7104 Adelphi Rd. | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First Middle Lost |
| Hyman | | | Bedsow | | Leah | | Gurewich |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| | | 052-09-0636 | | Mr. Henry Sheitelman (Son) same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio - Vascular</u> | | | | | | | |
| 4120 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) <u>Renal Disease</u> | | | | | | | 2 years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 442X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1967</u> , to <u>Jan 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Card</u> | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>William Brainin</u> | | | | | | 1/4/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| WM BRAININ | | 6124 Central Ave Capital Heights | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 1-5-68 | | King David Mem. Garden Falls Church, Virginia | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| B. Danzansky & Sons 3501 14th St. N.W. | | | | DATE JAN 8 1968 | | <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 01300 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01296 | | | |
|---|--|--|--|---|--|---|--|--|--|---------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
FLORA O. SINDELAR | | | | 2a. DATE OF DEATH Month Day Year
1 3 68 | | | | 2b. HOUR
7:50 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
2/19/22 | | 6. AGE (In years last birthday)
45 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Oklahoma | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1904 HENRY Rd. | | | |
| 14. FATHER'S NAME First Middle Last
John Owen | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret Stephens | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) | | | | 16b. SOCIAL SECURITY NO.
494-16-6202 | | 17. INFORMANT
Gilbert E. S indelar | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Anoxia (Edema)</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u>
(b) <u>Ventricular Thrombocytosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute Myocardial Infarction</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Emphysema; Bronchitis; Respiratory Insufficiency</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>36 Hours</u>
<u>36 Hours</u>
<u>36 Hours</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1959, to 1/3, 1968, that (I) (we) saw the deceased alive on 1/3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | 22b. SIGNATURE
Herman Maganzini M.D. DEGREE
22c. DATE SIGNED
1/4/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Herman Maganzini | | 22e. ADDRESS
50 W. Edmonston Dr., Rockville | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montg. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | | | ADDRESS
1331 Rock. Pike
Rockville, Md. | | 25a. REC'D BY REGISTRAR
JAN 9 1968 | | 25b. REGISTRAR'S SIGNATURE | | | |

[Faint, illegible handwriting]

[Faint, illegible handwriting]

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01301

CERTIFICATE OF DEATH

01297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>473</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park Md 20912</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanatorium + Hospital</u> | | | | d. STREET ADDRESS
<u>32 Tuckerman St N.W.</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Mollie</u> First <u>(NMN)</u> Middle <u>Sitnick</u> Last | | | | 4. DATE OF DEATH
Month <u>Jan</u> Day <u>1</u> Year <u>1968</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 15, 1913</u> 78 yrs. | |
| 9. AGE (In years lost birthday) | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Russia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Morris A Sadel</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Jennie ?</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>Medicare no. 517-56-6338A</u> | | 17. INFORMANT <u>Charles Sitnick</u> Address
<u>Husband (from pts. chart) as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>4200</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u>
<u>15 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetes mellitus</u> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>Jan 1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 19 <u>68</u> , and that death occurred at <u>11:40 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Arthur S. Bensen</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Jan 1, 1968</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>1-2-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Beth Shalom Cemetery Hillside, Maryland</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u> | | | | 25a. REC'D BY REGISTRAR
<u>3501 14th St. N.W. Washington, D.C. 20004</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

10328

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|------------------|--|---|--|-------------------------------------|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) JEFFREY FRANCIS SMITH | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 26 Year 1968 | | | 2b. HOUR M | | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 8-18-67 | 6. AGE (In years lost birthday) 5 YRS. 8 MONTHS 8 DAYS | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD Month 1 Day 26 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) MD | | 7b. CITIZEN OF WHAT COUNTRY? AMER. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY | | | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY Pro Geo | | 13c. CITY OR TOWN CHEVERLY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6329 LANDOVER RD | |
| 14. FATHER'S NAME First Middle Lost | | | 15. MOTHER'S MAIDEN NAME First Middle Lost | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT HOSPITAL CHART | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, Severe, Interstitial | | | | | | | | | | |
| 484X DUE TO, OR AS A CONSEQUENCE OF Pneumonitis | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 472X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED JAN. 27, 1968 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan 30, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) Colmar Manor Pro Geo | | (County) Md. (State) | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. RECEIVED BY REGISTRAR FEB 1 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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CERTIFICATE OF DEATH

01299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|---|--|--|--|--|------|---|---------------------------------|--|-----------------------------------|--|------------------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Robert William | | | | | Sohn | January 18 Day 1968 Year | | | 140P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | | Cauc. | | 24 December 1967 | | | YRS. 25 | | MONTHS 25 | | DAYS 25 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Charleston S.C. | | USA | | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | N/A | | | N/A | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| S. C. | | | N. Charleston | | | | | | | 5717 Salvo Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Ralph W. SOHN | | | Robbin Kelly | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| N/A | | | N/A | | | Charleston | | | S. C. | | |
| | | | | | | SN Ralph W. Sohn, USN, | | | 5717 Salvo St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 7461 Congenital Heart Disease--transposition of the great vessels | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 7547 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| Jan. 17, 1968 | | Transposition gr. vessels | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 6, 1968, to Jan. 18, 1968, that (X) (we) last saw the deceased alive on Jan. 18, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Perry Ah-Tye, M.D. | | | | | | | | | | Jan. 19, 1967 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Perry Ah-Tye, M. D. | | | | | | Naval Hospital, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-23-68 | | Jefferson Barracks Nat'l Cemetery, St. Louis, Missouri | | | | | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Funeral Home, 7557 Wisconsin Ave. Bethesda, Md | | | | | | | | DATE JAN 24 1968 | | Charles Judge | |

1980

OFFICE OF THE

1980

January 1, 1980

Dear Sirs:

I am writing to you regarding the matter of the

which is being handled by the

and the results of the

are as follows:

1. The first item is the

which is being handled by the

Very truly yours,

Enclosed for you are

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01304

CERTIFICATE OF DEATH

01300

| | | | | | | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Harrah Christine Sponde</i> | | | 2a. DATE OF DEATH
Month <i>1</i> Day <i>7</i> Year <i>68</i> | | | 2b. HOUR
<i>8:05</i> AM | | | | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>March 12, 1877</i> | | | 6. AGE (In years
lost birthday)
<i>90</i> YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country)
<i>Minnesota</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Holy Cross Hospital</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>Own Home</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Silver Spring</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>1211 Pinecrest Circle</i> | | |
| 14. FATHER'S NAME
First <i>Michael</i> Middle <i>Hardness</i> Last <i>Margaret</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>Yes</i> | | | 17. INFORMANT
<i>Dr. Myrtle S. Sponde</i> Address
<i>1211 Pinecrest Circle Silver Spring, Md.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>myocardial Infarct</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>arteriosclerotic Cardiovascular Disease</i>
<i>30 years</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>4201</i>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>5 days</i> | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>congestive heart failure</i> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 31, 1967</i> , to <i>JAN 7, 1968</i> , that (I) (we) last
saw the deceased alive on <i>JAN 6, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>George B. Patrick, Jr. M.D.</i> | | | DEGREE
<i>MD</i> | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>1-7-68</i> | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<i>George B. Patrick, Jr. M.D.</i> | | | 22e. ADDRESS
<i>9221 Coleville Rd
Silver Spring, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Trans-burial</i> | | | 23b. DATE
<i>Jan. 10, 1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Scheie Lutheran Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Mable Minnesota</i> | | | | | |
| 25a. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | | ADDRESS
<i>8434 Georgia Avenue
Silver Spring, Md.</i> | | | 25b. REC'D BY REGISTRAR
<i>JAN 10 1968</i> | | | 25c. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|--|--|---|---|---|
| 01305 | | 01301 | | |
| 1. DECEASED-NAME
(Type or print)
Rebe Florence Spencer | | 2a. DATE OF DEATH
Month 1 Day 30 Year 1968 | | 2b. HOUR
4:17 P.M. |
| 3. SEX
Female | 4. RACE
Cauc. | 5. DATE OF BIRTH
4/3/1888 | 6. AGE (In years
lost birthday)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
Avondale, Penna. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
University Nursing Home | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Government Employee | 12b. KIND OF BUSINESS OR
INDUSTRY
U.S. Govern. | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
14007 Eagle Court |
| 14. FATHER'S NAME
First Middle Last
Thomas Roach | 15. MOTHER'S MAIDEN NAME
First Middle Last
Anne Browning | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | |
| 16b. SOCIAL SECURITY NO.
yes | | 17. INFORMANT
Thomas L. Spencer 14007 Eagle Court
Rockville, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 436.9 Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Vascular Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Semblity
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 HRS
1-2 YRS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
331X POST OP HIP FRACTURE | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.O. No. City or Town County State | | |
| 22a. I certify that (1) (this hospital) attended the deceased from JAN 15 1968, to JAN 30 1968, that (1) (we) last
saw the deceased alive on JAN 15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (1) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Benjamin S. Miller MD | 22c. DATE SIGNED
Jan 30 1968 | 22d. PHYSICIAN'S
NAME (Type)
Benjamin S. Miller | | |
| 22e. ADDRESS
3824-34 ST
MR RAINIER Md. | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | 23b. DATE
Feb. 2, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | 23d. LOCATION (City or Town) (County) (State)
Rockville Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Humphrey, Inc. Silver Spring, Md. | 25a. REC'D BY REGISTRAR
DATE FEB 5 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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FOOTNOTES

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Fig. 1. 27

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CONCLUSIONS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01302 | |
|---|--|----------------------|--|--|--|---|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 01302 | |
| 1. DECEASED-NAME
(Type or Print) RAYMOND | | | First Middle Last A. SPHAR | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Jan. 7 1968 | | | 2b. HOUR M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 11-23-21 | | 6. AGE (In years last birthday) 46 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Pa. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH MONTGOMERY | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TRUCK DRIVER | | | 12b. KIND OF BUSINESS OR INDUSTRY Trucking | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA. | | | 13b. COUNTY NOBLESTOWN | | | 13c. CITY OR TOWN NOBLESTOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER Box 227 | | | 14. FATHER'S NAME First Middle Last Harry Sphar | | | 15. MOTHER'S MAIDEN NAME First Middle Last Esther Marsh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. 173-16-7120 | | | 17. INFORMANT Robert Sphar RFD#1 | | | ADDRESS Seneca, Pa. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Coronary Thrombosis with occlusion | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED JAN. 8, 1968 | | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (If not in town or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 1/16/68 | | | 23c. NAME OF CEMETERY OR CREMATORY County Burial Grounds | | | 23d. LOCATION (City or Town) (County) (State) Rockville, Montg., Md. | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 18 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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0-9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| First Middle Last
Thomas Lovell Squire, Jr. | | | | | Month Day Year
January 11, 1968 | | | 1:13 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
18 March 1916 | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Administ. Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Chemical | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
New Jersey | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
West Millington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
151 Thackeray Drive | |
| 14. FATHER'S NAME First Middle Last
Thomas Squire | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Jessie Corwin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (a, or unknown) (If yes give war or dates of service)
No -- | | 16b. SOCIAL SECURITY NO.
077-16-6826 | | 17. INFORMANT
The Medical Record Address
The Clinical Center, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial failure
3950
DUE TO, OR AS A CONSEQUENCE OF Rheumatic Heart Disease with Aortic Insufficiency and Atherosclerotic Coronary Artery Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Insufficiency and Atherosclerotic Coronary Artery Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
10 Years | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
411 x | | | | | | | | | |
| 19a. DATE OF OPERATION
11 Jan. 1968 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
with Aortic Insufficiency Rheumatic Heart Disease | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from January 7, 1968 , to January 11, 1968 , that he (we) lost saw the deceased alive on January 11, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Willis H. Williams M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
11 January 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Willis H. Williams, M.D. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Somerset Hill Cem. | | 23d. LOCATION (City or Town) (County) (State)
Basking Ridge, N.J. | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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11 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

18 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

19 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

20 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

21 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

22 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

23 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

24 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

25 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

26 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

27 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

28 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

29 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

30 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

31 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

32 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

33 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

34 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

35 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

36 1968 1:15 P
Jennings, J.
Jennings, J.
Jennings, J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Louise</i> | | | First <i>A.</i> | | Middle <i>STAM</i> | | Last | | 2a. DATE OF DEATH
Month <i>Jan.</i> Day <i>1</i> Year <i>1968</i> | 2b. HOUR <i>10:30</i> P | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Dec. 3, 1879</i> | | | 6. AGE (In years last birthday)
<i>88</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban Hosp.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Homemaker</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Chase</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>5516 Cedar Parkway</i> | | |
| 14. FATHER'S NAME
First <i>Colin</i> Middle <i>Ferguson</i> Last <i>Stam</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Annie</i> Middle <i>Roberts</i> Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>217-3 2-1293</i> | | 17. INFORMANT
<i>Sister</i> | | Address
<i>Susan R. Stam Same as Item 13.</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>adenocarcinoma of cecum</i>
DUE TO, OR AS A CONSEQUENCE OF <i>with metastasis to liver &</i>
(b) <i>widely in abdomen -</i>
DUE TO, OR AS A CONSEQUENCE OF <i>6 mos.</i>
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>1530 no</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes -</i> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR <i>A.M.</i> Month <i>Sept</i> Day <i>1</i> Year <i>1968</i>
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION <i>Street or R.F.D. No.</i> City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>28 Sept 1967</i> to <i>1 Jan 1968</i> , that (I) <i>we</i> last saw the deceased alive on <i>1 Jan 1968</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. H. Richwine M.D.</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2 Jan 68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>H. RICHWINE, M.D.</i> | | 22e. ADDRESS
<i>3322 WESTERN AVE - CHASE, MONTGOMERY CO, MD.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1-5-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Washington, D. C.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Md.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
<i>JAN 5 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

42:51

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01309
01305
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. LENGTH OF STAY in 1b
26 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
4501 Leland Street | | | | d. STREET ADDRESS
4501 Leland Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
KETURA GERTRUDE STANT | | | | 4. DATE OF DEATH Month Day Year
Jan. 27, 19 68 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 9, 1885 | |
| 9. AGE (In years last birthday)
82 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
Education | | 11. BIRTHPLACE (County & State, or foreign country)
Indiana | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
William Hyatt | | | | 14. MOTHER'S MAIDEN NAME
Jane Jackson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
412 Brewster Ave. Silver Spring, Md. | | 17. INFORMANT
Mary S. Dollins | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
410.9 DUE TO MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO ARTERIOSCLEROTIC HEART DISEASE
INTERVAL BETWEEN ONSET AND DEATH
15 MIN
30 MIN
4 YRS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
4201 DIA BETES MELLITUS | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from DEC 1, 1965 to JAN 27, 1968 , that (I) (we) last saw the deceased alive on JAN 24, 1968 , and that death occurred at 4:07 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Thomas F. O'Connor M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
JAN/27/68 | |
| 22c. PHYSICIAN'S NAME (Type)
THOMAS F. O'CONNOR | | | | 22d. ADDRESS
8218 WISCONSIN AVE, BETHESDA, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1-31-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Crown Point Cemetery | | 23d. LOCATION (City, town or county) (State)
Kokoma, Indiana | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 01310 | | CERTIFICATE OF DEATH | |
| 01306 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>109 Frederick Ave.</u> | | d. STREET ADDRESS
<u>109 Frederick Ave.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Mamie L. STARR</u> | | 4. DATE OF DEATH
Month <u>January</u> Day <u>9</u> Year <u>1968</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 20, 1892</u> |
| 9. AGE (In years last birthday) yrs. <u>75</u> | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Georgia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Willis Isreal</u> | | 14. MOTHER'S MAIDEN NAME
<u>Alice Howell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>Otis Isreal - (SON)</u> | | Address <u>Rockville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>4109</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion (?) (Hard dead)</u>
DUE TO <u> </u>
(b) <u>Senile arteriosclerosis cardiovascular disease</u>
DUE TO <u> </u>
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>few days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Recent influenza - fresh</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town) (County) (State)
<u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>Jan 9</u> , 19 <u>68</u> , that (I) <u>was</u> last saw the deceased alive on <u>Jan. 3</u> , 19 <u>68</u> , and that death occurred at <u>5 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W.R. Lintner</u> | | 22b. DATE SIGNED
<u>1/9/68</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wm A. Lintner</u> | | 22d. ADDRESS
<u>40 S. Washington St. Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>JAN. 13, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Park Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville Montg. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR
<u> </u> | |
| ADDRESS
<u>Rockville, Md.</u> | | DATE
<u>JAN 18 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u> </u> | | | |

07300

01310

JAN 18 1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01311 CERTIFICATE OF DEATH 01307 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) John Bradford STETSON | | | 2a. DATE OF DEATH
January 30 Day 68 Year | | | 2b. HOUR
9:15 P | | | |
| 3. SEX
Male | | 4. RACE
Caucasion | | 5. DATE OF BIRTH
28 OCT 1921 | | 6. AGE (In years last birthday)
46 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U.S. NAVY | | 12b. KIND OF BUSINESS OR INDUSTRY
Military | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Florida | | 13b. COUNTY
Atlantic Beach | | 13c. CITY OR TOWN
Atlantic Beach | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1705 OCEAN BLVD. | |
| 14. FATHER'S NAME
Bradford STETSON | | | 15. MOTHER'S MAIDEN NAME
Melvina URBAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Nancy M. STETSON 1705 Ocean Blvd, Atlantic Beach, Florida | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Leiomysarcoma retroperitoneum
1580
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
158X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 20 NOV , 19 67 , to 30 JAN , 19 68 , that (X) (we) last saw the deceased alive on 30 JAN 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. J. FOUTY, M. D. | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
31 Jan. 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
W. J. FOUTY, M. D. | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
2/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | |
| 24. FUNERAL DIRECTOR
Falls Church Funeral Home
1102 West Broad St., Falls Church, Va. | | | | 25a. REC'D BY REGISTRAR
FEB 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01307

01317

DATE: 1958 03 28

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

CERTIFICATE OF DEATH

01312

01308

| | | | | | | | | | |
|--|---------|--|------------------|---|--|---|--|--|------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Elizabeth | | | | Stewart | Month Day Year
JAN. 11 1968 | | | 2 ⁴⁰ A M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | White | | 9/12/96 | | 71 YRS. | | MONTHS | DAYS | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Pennsylvania | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban Hospital | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| New Jersey | | V Maryland | | Margate | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 203 N. Argyle | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Michael | | Patrick | Travis | | Elizabeth | | | | Tobin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | | R#2 Scotch Irish Sham
John Stewart - son - Schuylkillville, Penna. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Coronary thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>4201</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
24 hrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<u>Pulmonary Thrombosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 29, 1962</u> , to <u>Jan 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Sidney J. Cohen, M.D.</u> | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>Jan 11, 1968</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Sidney J. Cohen, M.D.</u> | | | | 22e. ADDRESS
<u>50 W. Edmonston Dr., Rockville, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 1-13-68 | | Ivy Hill Cemetery | | Philadelphia, Penna. | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01300

DEPARTMENT OF HEALTH

01310

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "DEPARTMENT OF HEALTH" and "01300" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01313 CERTIFICATE OF DEATH 01309 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Alma | | | Charity | | | January 17 1968 | | 5:50 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | 9 March 1908 | | 59 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| New Jersey | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | The Clinical Center | | Housewife | | -- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington Williamsport | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 23 Hoffman Drive | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Carman | | | Wilson | | | Frances Hunt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | Not Available | | The Medical Records Address
The Clinical Center, Bethesda, Md. 20014 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal failure / ureteral obstruction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Epidermoid carcinoma to retroperitoneum</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Epidermoid carcinoma of Pharynx</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 Days
2 Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>December 27, 1967</u> , to <u>January 17, 1968</u> , that (X) (we) last saw the deceased alive on <u>January 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Frederick R. Eilber</u> M.D. DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Frederick R. Eilber, M.D.</u> | | | | | 22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, OR DISPOSITION (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-20-68 | | Cedar Lawn Memorial Gar. | | Hagerstown, Wash, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Minnich Funeral Home, Hagerstown, Md. | | | | | DATE JAN 22 1968 | | <u>Charles Jones</u> | | |

01313

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) JAMES WALTER STONE | | | | | | 2a. DATE OF DEATH
Month 1 Day 4 Year 68 | | | 2b. HOUR
4 A. M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
March 18, 1919 | | | 6. AGE (In years last birthday)
48 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Air Conditioning Engr. | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11802 Claridge Road | | |
| 14. FATHER'S NAME First James Middle A. Last Stone | | | | 15. MOTHER'S MAIDEN NAME First Francis Middle E. Last Davis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war and dates of service)
WW II | | 16b. SOCIAL SECURITY NO.
578-05-5252 | | 17. INFORMANT
Selenia Stone Address 11802 Claridge Road Silver Spring, Md. Wheaton | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Concussion of the Colon with undigested contents
153.8
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
153.8 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 10 , 19 67 , to Jan 4 , 19 68 , that (I) (we) saw the deceased alive on Jan 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Michael R. Dobridge | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 4, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Michael R. Dobridge | | 22e. ADDRESS
12600 Parkland Dr. Rockville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 6, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | | | | | |
| 24. GENERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR
C. Glen Carter | | 25b. REGISTRAR'S SIGNATURE
8434 Georgia Ave. Silver Spring, Md. | | DATE
JAN 8 1968 | | | | | |

1570

DATE: 11/23/19

5131 31 2000

notified

1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

1. The Commission has received information from the Government of the Republic of the Philippines that the Government is planning to conduct a series of military operations in the area of the Philippine Sea, which is a part of the South China Sea. The Commission is concerned that these operations may result in the displacement of a large number of people, and it is therefore requesting the Government to provide information on the number of people who are expected to be displaced, and on the measures that are being taken to ensure that they are adequately protected and assisted.

100

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

END

242

•

02-2-79-75

• **Stress Management:** Stress management techniques such as deep breathing, meditation, and yoga can help reduce stress and improve overall health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with medical examiner at Physd

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 01315 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01311 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print)
First Middle Last
Clara Storing | | | 2a. DATE OF DEATH
Month Day Year
1 18 68 | | | 2b. HOUR
1 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2-22-75 | | 6. AGE (In years lost birthday)
92 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
GERMANY | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wheaton Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
WASH. D.C. | | 13c. CITY OR TOWN
WASH. D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
4656 GARFIELD ST. N.W. | | 14. FATHER'S NAME
First Middle Last
Julius Storing | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Regina Stocker | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
NO | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 485X Bronchopneumonia lobular
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Generalized arteriosclerosis | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks | |
| 19a. DATE OF OPERATION
11-30-67 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hip surgery | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
Not | | 21b. TIME OF INJURY
HOUR A.M. P.M.
Month Day Year
11 28-67 | | 21c. HOW INJURY OCCURRED • (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell inside his bed in Nursing Home | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Nursing Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
11901 Ga Ave Wheaton Md | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov, 1967, to 1-17-1968, that (I) (we) last saw the deceased alive on 1-17-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C P Ryland | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-18-68 | |
| 22d. PHYSICIAN'S NAME (Type)
C P RYLAND | | | | 22e. ADDRESS
4400-49 St NW Washington 2006 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-19-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
UNION CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
OH RICHSVILLE OHIO | |
| 24. FUNERAL DIRECTOR
Jas. Grawen's Sons 5130 WISCONSIN AVE. WASH. D.C. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01312

CERTIFICATE OF DEATH

01311

DIVISION OF HEALTH, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, N.Y.

JAN 3 1958

01316

CERTIFICATE OF DEATH

01312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | |
|---|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Harry J. Stottmeyer Jr.</i> | | | 2a. DATE OF DEATH <i>Jan 11 68</i> | | | 2b. HOUR <i>1:30 A M</i> | | | | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>4/18/32</i> | | 6. AGE (In years last birthday) <i>35</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Shop Foreman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>State Roads Comm.</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Dickerson</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>Box 64</i> | | |
| 14. FATHER'S NAME First <i>Harry</i> Middle <i>Stottmeyer</i> Last <i>Mildred</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Mildred</i> Middle <i>R</i> Last <i>Loake</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>Yes Army</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. <i>331X</i> | | 17. INFORMANT <i>Brother Walter Stottmeyer</i> Address <i>Dickerson Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i>
431.9
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Antisepsis pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>6 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>49°</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>331X</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>2-8-68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cerebral aneurysm</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-5-68</i> , 19 <i>1968</i> , to <i>1-11-68</i> , 19 <i>1968</i> , that (I) (we) last saw the deceased alive on <i>1-11-68</i> , 19 <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>J.P. Murphy</i> | | 22c. DATE SIGNED <i>1-12-68</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>J.P. Murphy</i> | | 22e. ADDRESS <i>1904 R St NW, DC.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/13/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Monocacy</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Beallsville Mont. Md.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>William C. Hill</i> | | ADDRESS <i>Barnesville, Md.</i> | | 25a. REC'D BY REGISTRAR <i>JAN 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>James Judge</i> | | | | |

01310

01310



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|-------------------|---|--|--|--|--|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) THELIS B. STUART | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
Jan. 26, 1968 | | | 2b. HOUR
7:15 A M |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Dec. 12, 1909 | | 6. AGE (In years lost birthday)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7803 Custer Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Principal | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7803 Custer Road | |
| 14. FATHER'S NAME First Middle Last
J. W. Bowden | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lucie Courtney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
219-36-7644 | | 17. INFORMANT Address 808 Law Rd/ Fayetteville, N.C.
Zolly Bowden | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA STOMACH
1519
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) LIVER METASTASES
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 MONTHS
3 MONTHS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
1518 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963 , 19____, to JAN 25, 1968 , that (I) (we) last saw the deceased alive on 1-25-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Philip R. James | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-26-68 | |
| 22d. PHYSICIAN'S NAME (Type)
PHILIP R. JAMES | | | | 22e. ADDRESS
Washington Clinic
Washington, D. C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01113

01310

1931

STATE

1931

30

1931

1931

1931

Virginia

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

Richmond

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|------------------|--|
| 01313 | | 01314 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Victor | | First Middle Last C. SWEARINGEN | | 2a. DATE OF DEATH
Month Day Year January 15 1968 | | 2b. HOUR
1100 P M | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
1 June 1899 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U.S. Air Force | | 12b. KIND OF BUSINESS OR INDUSTRY
- - - | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
District of Columbia | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6436 Barnaby Street, N.W. | | | |
| 14. FATHER'S NAME
Charles C. Swearingen | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Lena Hubble | | First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
yes | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
- - - | | 17. INFORMANT
N.W. Washington
Mrs. Beth Swearingen, 6436 Barnaby Street, | | Address D. C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u>
(b) <u>atrial fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>arteriosclerotic heart disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>AdenoCarcinoma of the Prostate Gland</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 26</u> , 19 <u>67</u> , to <u>Jan. 15</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Jan. 15</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>James L. Snyder, M.D.</u> | | DEGREE
James L. Snyder, M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Jan. 16, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
James L. Snyder, M.D. | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1-18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR
Jos. Gawler & Sons | | ADDRESS
5130 Wisconsin Ave., N.W. Washington, D.C. | | 25a. REC'D BY REGISTRAR
DATE JAN 22 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>James L. Snyder</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|---|
| Item 6 Film G396 1/18/68 kk | | | | | CERTIFICATE OF DEATH | | | | |
| 01315 | | | | | 01315 | | | | |
| 1. DECEASED-NAME
(Type or print) ELIZABETH | | | First | Middle | Last | 2a. DATE OF DEATH
Month 1 Day 11 Year 68 | | | 2b. HOUR
1105 |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1-1-1885 | | | 6. AGE (In years last birthday)
83 82 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
NEW HAMPSHIRE | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLI CROSS HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
1st. OF COL. | | 13b. COUNTY
KK | | 13c. CITY OR TOWN
WASHINGTON | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
4629 TILDEN ST. NW | |
| 14. FATHER'S NAME
First JAMES Middle MURPHY Last UNK. | | | 15. MOTHER'S MAIDEN NAME
First UNK. Middle BOHAN Last BOHAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war and date of service)
NO | | 16b. SOCIAL SECURITY NO.
027-26-8186 | | 17. INFORMANT
PHILIP SWEENEY | | Address
4629 TILDEN ST. N. W. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular collapse
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) uremia
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immed.
several months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 9 19 59 , to Jan 11 19 68 , that (I) (we) last saw the deceased alive on Jan 11 19 68 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Wilfred R. Ehrmantraut | | | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/11/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Wilfred R. Ehrmantraut, M.D. | | | | 22e. ADDRESS
11125 Rockville Pike, Rockville, Md. | | 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
JAN. 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOSEPH'S | | 23d. LOCATION (City or Town) (County) (State)
PITTSFIELD, MASS | | | |
| 24. FUNERAL DIRECTOR
JOSEPH GAWLER SONS | | | | ADDRESS
5130 WISC. AVE. N. W. WASH., D. C. | | 25a. REC'D BY REGISTRAR
DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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CERTIFICATE OF DEATH

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|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North Chevy Chase</u> | | c. LENGTH OF STAY IN tb
<u>years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>8917 Conn. Ave.</u> | | d. STREET ADDRESS
<u>8917 Conn. Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Bruno</u> First Middle Last <u>SWIENSKI</u> | | 4. DATE OF DEATH
Month <u>Jan.</u> Day <u>5</u> Year <u>1968</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 19, 1897</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Coal Miner-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>179-10-4913</u> | |
| 17. INFORMANT
<u>Wife</u> | | Address
<u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
DUE TO (b) <u>Arteriosclerosis and pulmonary insufficiency</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>332X 2. Coronary artery atherosclerosis</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>Nine 19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/17, 1965</u> , to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1/5 1968</u> , and that death occurred at <u>8:25 M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John B. Umhau</u> | | 22b. DATE SIGNED
<u>1/5/68</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN B. UMHAU</u> | | 22d. ADDRESS
<u>8805 Conn. Ave. Chevy Chase Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>1-9-68</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Adalbert's Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Glen Lyon, Penna.</u> |
| 24. FUNERAL DIRECTOR
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 11 1968</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF DEATH

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FOR STATE HEALTH DEPT.
any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|--|--------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| John | | none | | Switzer | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR | | 2:00 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| M. | W. | Nov. 20-1918 | | 49 YRS. | | MONTHS DAYS | | HOURS MIN. | | Month Day Year | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | 2d. HOUR | |
| Texas | | U.S.A. | | | | Montgomery | | | | 5:15 P.M. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | 6624 Hillendale Rd. | | Elevator operator | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md. | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6624 Hillendale Rd. | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Paul | | E | | Switzer | | | | Katharine | | Miller | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Wife | | ADDRESS | | Same as Item 13. | |
| No | | 578-09-9740 | | Anna E. Switzer | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia by Hanging -</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Min.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | 2:00 P.M. Jan 8 1968 | | Hung. Self. with Lamp cord | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | Home | | 6624 Hillendale Rd. Bethesda. Montgomery Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John G. Ball | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | JOHN G. BALL | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Jan. 8, 1968. | |
| ADDRESS (Street, city, town, or county) | | Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 1-11-68 | | Ft. Lincoln Cem. | | Prince George County, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | DATE JAN 12 1968 | | f Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|--------------------------------------|--------------------------------|
| 01322 | | 01318 | | | |
| 1. DECEASED-NAME
(Type or print) | | First Middle Last | 2a. DATE OF DEATH
Month Day Year | 2b. HOUR | |
| EARL Bowman Swope | | | 1 3 68 | 10 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| Male | White | 8-4-1922 | 45 YRS. | | |
| 7a. BIRTHPLACE (State or foreign
country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| Md. | U.S.A. | | Montgomery Md. | | |
| 1d. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Takoma Park | Washington Sanitarium & Hosp. | | Musician | Orchestra | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| Md. | Prince Georges | Riverdale | | 6000 67th Ave. Apt. 1 | |
| 14. FATHER'S NAME
First Middle Last | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | |
| George A. Swope | Virgia E. Bowman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| No | 577-24-6991 | Hospital Record | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| 571.0 Hepatic failure | | | hours | | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. 5811 Laennec's cirrhosis | | | years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Esophageal varices - bleeding | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/29, 1967, to 1/3, 1968, that (I) (we) last
saw the deceased alive on 1/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| Kenneth Cruze | | 1/4/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type) | 22e. ADDRESS | 22f. REGISTRAR'S SIGNATURE | | | |
| Kenneth Cruze | 831 University Blvd-East, Md. | Charles Judge | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | 1/6/68 | Ft Lincoln | Bladensburg Md. | | |
| 24. FUNERAL DIRECTOR | ADDRESS | | 25a. REG'D BY REGISTRAR
DATE | 25b. REGISTRAR'S SIGNATURE | |
| LEE FUNERAL HOME | 300 45TH ST NE | | JAN 8 1968 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 01323 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01319 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Blanche Teape</i> | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
<i>January 16 1968</i> | | | | | | | | | | 2b. HOUR
<i>11:00 PM</i> | | | | | | | | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>Cauc</i> | | | 5. DATE OF BIRTH
<i>October 25 1882</i> | | | 6. AGE (In years last birthday)
<i>85</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Wash. D.C.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Wash. Grove</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>* Rixx 105 Grove Ave.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>own home</i> | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Wash. Grove</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>* Rixx 105 Grove Ave.</i> | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
<i>Thomas P. Koontz</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Ada Barron</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
<i>no</i> | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>216-46-1077</i> | | | 17. INFORMANT Address
<i>William K. Teepe 1 Circle Wash. Grove</i> | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>428X</i> IMMEDIATE CAUSE (a) <i>Myocarditis</i>
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>4222</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19__, to <i>1/16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1/11</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Luciano I. Lee</i> | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>1-16-1968</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Luciano I. Lee</i> | | | 22e. ADDRESS
<i>108 N FREDERICK AVE. GAITHERS BURG, MD.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Jan. 20, 1968</i> | | | 23b. DATE
<i>Rock Creek Cemetery</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Washington D.C.</i> | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Clark E. Wisor</i> | | | ADDRESS
<i>Silver Spring, Md.</i> | | | 25a. REC'D BY REGISTRAR
<i>Warner E. Pumphrey, Inc.</i> | | | DATE
<i>JAN 23 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|---|--|--|--------------------------------------|---|--|
| 01324 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01320 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONT GOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT GOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | c. LENGTH OF STAY IN TB <u>14 mos</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills N.H.-4011 Randolph Rd.</u> | | d. STREET ADDRESS <u>907 Lamberton Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Anna Thompson</u> | | 4. DATE OF DEATH <u>January 14, 1968</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 1, 1886</u> | 9. AGE (In years last birthday) <u>81 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailoring</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u> | |
| 13. FATHER'S NAME <u>Shmuel Pinhas</u> | | 14. MOTHER'S MAIDEN NAME <u>Rose Corsicas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>226-44-9019-A</u> | | 17. INFORMANT <u>Mrs. Frieda King</u> Address <u>8201 - 16th Street, Silver Spring, MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>4379</u> IMMEDIATE CAUSE (a) <u>Cerebral ARTERIOSCLEROSIS</u>
DUE TO (b) <u>Generalized ATHEROSCLEROSIS</u>
DUE TO (c) <u>3347</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 YRS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema, ARTERIOSCLEROTIC HEART DISEASE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>67</u> , to <u>1/14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>68</u> , and that death occurred at <u>5:30 AM</u> , from causes on and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>R.T. Benack MD</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>1/14/68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.T. BENACK MD</u> | | 22d. ADDRESS <u>4115 Colie Drive Wheaton MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Jan. 16, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church, Virginia</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Donald M. Stein</u> | | ADDRESS <u>232 Carroll St., N.W., Wash., D.C.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Jones</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | |
| DATE <u>JAN 19 1968</u> | | | | | |

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DAVID L. MCKINLEY

FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------|---|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print) CHARLES LEE THOMPSON | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 14 Year 1968 | | | 2b. HOUR 1:37 PM | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 11-20-32 | 6. AGE (In years last birthday) 35 YRS | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month 1 Day 14 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & HOSP | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY MONT. | | 13c. CITY OR TOWN S.S. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Wm. Emerson Middle Last | | 15. MOTHER'S MAIDEN NAME
First Bessie Middle Thompson Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 578-44-2538 | |
| 17. INFORMANT Mrs. Mary A. Thompson | | ADDRESS 15- Manchester Pl. AP MD | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Extreme Internal Injuries with Hemothorax and Hemoperitoneum
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8160 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8234 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 11-14-68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased driver, lost control of car and struck tree | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street | | 21f. LOCATION Street or R.F.D. No. 8105 Carroll Ave. City or town Tak. Pl. County Montg. State MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | M.D. Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED JAN. 14, 1968 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP | | ADDRESS M.D. 254 Carroll St. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Chesapeake, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE JAN 15-1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. Luke's | | 23d. LOCATION (City or Town) (County) (State) Thioburg Rd & Hwy. Md. | |
| 24. FUNERAL DIRECTOR John J. Walters | | ADDRESS 254 Carroll St. | | 25a. REC'D BY REGISTRAR JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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Charles Lee Thompson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01322 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
HELEN E. THORNE | | | 2a. DATE OF DEATH
Month 24 Day 68 Year
JAN | | | 2b. HOUR
1:45 A M | | | |
| 3. SEX
F | | 4. RACE
CAU | | 5. DATE OF BIRTH
12/29/14 | | 6. AGE (In years last birthday)
53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Dental Assistant | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
709 Gilbert St. | |
| 14. FATHER'S NAME First Middle Last
J. LeRoy Elliott | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Bessie Vaughan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO
577-03-9365 | | 17. INFORMANT Address
Fred L. Thorne same as #13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION
1/22/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
TRACHEOTOMY FOLLOWING CARDIAC ARREST | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/13 , 19 67 , to 1/23 , 19 68 , that (I) (we) last saw the deceased alive on 1/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Edward S. Mehlman , M.D. DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) Edward S. Mehlman | | | | | 22e. ADDRESS MEDICAL ARTS BUILDING- 6480 NEW HAMPSHIRE AV. TR PK, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
1/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md. | | | |
| 24. FUNERAL DIRECTOR
S.H. Hines Co. Wash D.C. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

01332

01332

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

HEATH

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THOMAS

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OF

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THOMAS

THOMAS

CONSTITUTIONAL

ACUTE MYOCARDIAL INFARCTION

INTERSTICTIC HEART DISEASE

THOMAS

THOMAS

11/2/00

1875

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THOMAS

1875

11/2/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115-1
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|------------------------|--|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01323 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| EDGAR | | | | HAROLD | TOLBERT | Month JAN Day 1 Year 68 | | | 3:30 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| MALE | | WHITE | | JUNE 3-1902 | | 65 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| SPENCER N.C. | | U.S.A | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | | Suburban | | | Pres. Colonial Storage Co | | Moving Storage. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | BETHESDA | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5602 Springfield Dr. | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| SAMUEL | | | ANDERSON | | TOLBERT | LUCY JANE | | | | LAMPKIN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| YES | | | 1917-1919 | | unknown | | | Mary m Tolbert same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 466X Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Bronchitis Acute
DUE TO, OR AS A CONSEQUENCE OF
(c) Pulmonary fibrosis and emphysema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
525X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hours
5 days
4 3/4 years | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1960, to Jan 1, 1968, that (I) (we) last saw the deceased alive on Dec. 30, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
FRANK S. BACON | | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Jan 1, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 1/4/68 | | Parklawn Cemetery | | | Rockville, Montgomery, Md. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., Wash., D. C. | | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 5 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

01326

CERTIFICATE OF DEATH

01324

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>8201 - 16th Street, Apt. 524</i> | | d. STREET ADDRESS
<i>8201 - 16th Street, Apt. 524</i> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<i>ANNE TRACHTENBERG</i> | | 4. DATE OF DEATH Month Day Year
<i>JAN 15 1968</i> | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>AUG 16, 1890</i> |
| 9. AGE (In years last birthday)
<i>77</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<i>RUSSIA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>DAVID EISENBERG</i> | | 14. MOTHER'S MAIDEN NAME
<i>DINA STEINBERG</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>NO</i> | | 16. SOCIAL SECURITY NO.
<i>220-44-8002</i> | |
| 17. INFORMANT
<i>Charles Stern</i> | | Address
<i>1220 East-West Hghwy. #207 Silver Spring, Maryland.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>410.0</i> DUE TO <i>Coronary Heart Failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Infarction</i>
(c) <i>Coronary Atherosclerosis Heart Disease</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4201 Hypertension, Essential</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 hrs</i>
<i>12/6/67</i>
<i>Dec 1964</i> | |
| 21. I certify that I attended the deceased from <i>Dec 6, 1967</i> , to <i>Jan 15, 1968</i> , that I last saw the deceased alive on <i>Jan 14, 1968</i> , and that death occurred at <i>2:15</i> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<i>4201 - CONNECTICUT AVE. N.W. WASH. DC.</i> | | | |
| ACTUAL SIGNATURE <i>William S. Miller</i> M.D. | | | |
| PHYSICIAN'S NAME (Type) <i>William S. Miller M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 22b. DATE THEREOF
<i>Jan. 16, 1968</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Lebanon Cemetery</i> | 22d. LOCATION (City, town, or county) (State)
<i>Hyattsville, Maryland.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Donald M. Stern Hebrew Memorial Funeral Home</i> | | 24a. REC'D BY REGISTRAR
<i>JAN 19 1968</i> | |
| 24b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

BF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01325

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Wesley</i> First Middle Last <i>VAN GILDER</i> | | | 2a. DATE OF DEATH
Month Day Year <i>January 11 1968</i> | | | 2b. HOUR
<i>9 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>10-11-96</i> | | 6. AGE (in years last birthday)
<i>71</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>West Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>America</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Washington Sen. & Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Retired Valt Worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>405 Joseph St.</i> | | 14. FATHER'S NAME First Middle Last
<i>John W. Van Gilder</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Ann Boyce ?</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>216-22-0158</i> | | 17. INFORMANT
<i>Hospital Records</i> | | Address
<i>Takoma Park, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Neoplasm of the brain</i>
<i>191X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>unknown</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>1930</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 8, 1968</i> , to <i>Jan 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 10, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Eino Magi MD</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>Jan 11, 1968</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>EINO MAGI</i> | | 22e. ADDRESS
<i>831 University Blvd. E., Silver Spring</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>1/14/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Union Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Spencerville, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Yson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i> | | | | 25a. REC'D BY REGISTRAR
<i>JAN 16 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

MEDICAL CERTIFICATION

01130

OFFICE OF THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| MARY PILAR VAZQUEZ | | | | Jan. 28 1968 | | | | 3:25 p.m. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | CAUCASIAN | | DEC. 4, 1881 | | | | 86 1/2 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | |
| CUBA | | AMERICA | | | | | | MONTGOMERY | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | | | WASHINGTON SANITARIUM & HOSPITAL | | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md. | | | | PRINCE GEORGE | | LANHAM | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7419 FINNS LANE | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | |
| ANTONE ESTRADA | | | | AS ROSARIO GIL | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | Address | |
| No | | | | 579-10-1352-A | | Daughter - Information sheet - same as deceased | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 433.9 CARDIAC ARREST | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS AND ENCEPHALOMALACIA 2 YEARS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | | | 30 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 332x RENAL FAILURE SECONDARY TO ARTERIOGRAPHOSCLEROSIS | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1:20, 1968, to 1:28, 1968, that (I) (we) last saw the deceased alive on 1:28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | | | |
| Louis Gillespie, Jr. M.D. | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | |
| Louis GILLESPIE, JR. | | | | 1716 N ST. N.W., WASHINGTON, D.C. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 1/31/68 | | Prospect Hill Cem. | | | | Wash., D.C. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Nalley's Funeral Home Inc. | | | | ADDRESS: Mt. Rainier, Maryland | | | | DATE: FEB 2 1968 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|------------------------|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) NOBLE First Middle Ledell Last Veirs | | | | | | 2a. DATE OF DEATH Month 1 Day 7 Year 68 | | | 2b. HOUR M | | | |
| 3. SEX MALE | | 4. RACE CAUC | | 5. DATE OF BIRTH 10/22/89 | | | 6. AGE (in years lost birthday) 78 YRS | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) D. C. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY Stotts & Co. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3510 Jeffry Street | | |
| 14. FATHER'S NAME First Samuel Middle Veirs Last Skillman | | | | 15. MOTHER'S MAIDEN NAME First Sallie Middle U. Last Skillman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 577-07-1088 | | 17. INFORMANT L. Mr. Noble X. Veirs, Jr. Address 3510 Jeffry St. Silver Spring, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 S HOCK
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY THROMBOSIS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 hour
36 hours
36 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY , 19 64 , to JAN 7 , 19 68 , that (I) (we) last saw the deceased alive on JAN 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Serach T. Kimble MD DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-7-68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Serach T. Kimble | | | | 22e. ADDRESS 9801 Georgia Ave Silver Spring, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | Jan. 10, 1968 | | Lake Wales Cemetery | | Polk County, Florida | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME (Type) | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Warner E. Pumphrey, Inc. | | C. Glen Carter Georgia Ave. Silver Spring, Md. | | JAN 10 1968 | | Charles Judge | | | | | | |

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CERTIFICATE OF DEATH

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| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Francis Logan Wahler | | | 2a. DATE OF DEATH
Month January Day 28 , Year 1968 | | | 2b. HOUR
2:15 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
20 July 1903 | | 6. AGE (In years lost birthday)
64 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
District of Columbia | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
803 Alabama Avenue, S.E. | | 14. FATHER'S NAME
First Valentine Middle Wahler Last Wahler | | 15. MOTHER'S MAIDEN NAME
First Rose Middle Marie Last Walker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16b. SOCIAL SECURITY NO.
578-38-3203 | | 17. INFORMANT
The Medical Records Address
The Clinical Center, Bethesda, Maryland 20014 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lung Abscess with Pseudomonas Septicemia
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF
(c) 203X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 203X | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 weeks
2-1/2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)
Acute Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from January 6 , 19 68 , to Jan. 28 , 19 68 , that (X) (we) last saw the deceased alive on January 28 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (initials) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Michael Emmer MD | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
29 January 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Michael Emmer, M.D. | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan. 31, 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
Simmons Bros. | | ADDRESS
1661-Gd. Hope Rd. SE. DC | | 25a. REC'D BY REGISTRAR
FEB 1 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF CHARGE

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Francis J. Ryan, M.D., Director, The Clinical Center, National Institutes of Health, Bethesda, Maryland

30 Jan 1962

Washington, D.C.

The Clinical Center, National Institutes of Health, Bethesda, Maryland

Office of the Director, National Institutes of Health, Bethesda, Maryland

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|--|---------|--|--------|--|---|--|--------------------------|----------------------------|-------|------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| Adia D. Wakefield | | | | | MATED <input checked="" type="checkbox"/> | | Jan | 18 | 1968 | 8 A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS
DAYS | 2c. DATE PRONOUNCED DEAD | | Month | Day |
| female | white | Dec-24-1898 | | 69 YRS | | | Jan-18 | | Year | 1968 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Penna. | | U.S.A. | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Gaithersburg | | 42 Deer Park Drive Apt 304 | | HOUSE WIFE | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Maryland | | Montgomery Gaithersburg | | | | 42 W. Deer Park Dr | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Same as Item 13. |
| Hugh Torrance | | Althea Wilberham | | No | | Unknown | | Elmer Muth | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) <u>coronary arteriosclerosis with occlusion</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | John G. Ball | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | JOHN G. BALL | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | Jan-19-1968 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Bethesda, Md. | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 1-22-68 | | Allegheny Cty. Mem. Pk. | | Allegheny County, Penna. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | JAN 24 1968 | | Charles Judge | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|------------------------------|--|--|---|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| WILLIAM | | | WALKER | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 1-3 1968 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | |
| MALE | NEGRO | July 13, 1907 | 60 YRS. | | | | | 1 Day 3 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Virginia | | U.S.A. | | | | MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| TAKOMA PARK | | | WASH. SAN. & HOSP. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | MONTGOMERY | | SILVER SPRING | | | | 2222 KANSAS AVE. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| MORRIS WALKER | | | MARGARET | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>due to Acute Alcoholism</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>3220</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | M.D. ASSISTANT MEDICAL EXAMINER | | | JAN. 4, 1968 | | | | |
| BELDEN R. REAP | | | DEPUTY MEDICAL EXAMINER | | | | | | | |
| BELDEN R. REAP M.D. | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 1/9/68 | | Ash Memorial Cam. | | Sandy Spring, Montg. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Robert L. Snowden | | | Rockville, Md. | | | DATE JAN 12 1968 | | Richard J. Judge | | |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 01335 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01331 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
ANDREW TUCK WALLACE | | | 2a. DATE OF DEATH Month Day Year
JAN 17 1968 | | | 2b. HOUR
11 35 A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1-22-'94 | | 6. AGE (In years last birthday)
73 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
AMERICA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON SAN+HOSP | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
GOVT. WORKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1105 NAVAHO DR. | | 14. FATHER'S NAME First Middle Last
SAMUEL WALLACE | | 15. MOTHER'S MAIDEN NAME First Middle Last
NETTIE HIGGINS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
213-44-6613 | | 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 162.1 Aspiration pneumonia minutes
DUE TO, OR AS A CONSEQUENCE OF (b) recurrent carcinoma months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162.1 Bronchogenic carcinoma years
DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal obstruction secondary recurrent carcinoma
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
1/16/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ESOPHAGEAL + BRONCHIAL STENOSIS - 2° recurrent CA | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased, from JAN 14, 1968, to JAN 17, 1968, that (I) (we) lost saw the deceased alive on JAN 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Kenneth Cruze | | | | DEGREE
ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/17/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Kenneth Cruze, M.D. | | | | 22e. ADDRESS
831 University Blvd., E., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
1/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., Washington, D.C. | | | | 25a. REC'D BY REGISTRAR
DATE JAN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
James Judge | |

01338

01338

01338 01338 01338 01338 01338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
ERRATHA (LAYNE) E WALLACE | | | 2a. DATE OF DEATH Month Day Year
1 7 68 | | | 2b. HOUR
M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12/11/30 | | 6. AGE (In years last birthday)
37 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Newton Mass. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Sally Grace Silver Spring | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Accounting | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8304 Lenox Ave - | |
| 14. FATHER'S NAME First Middle Last
Jenners B. Jenners | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Welch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
No 26-5185 | | 17. INFORMANT
Jenners B. Jenners | | Address
8304 Lenox Ave Silver Spring Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Bilected Pulmonary Edema
5770
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5870
(b) Acute necrotizing Pancreatitis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
5 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Left Ventricular Hypertrophy. | | | | | | | | | |
| 19a. DATE OF OPERATION
1-3-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute abdomen | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 6 , 19 66 , to Jan 7 , 19 68 , that (I) (we) last saw the deceased alive on Jan 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Arthur S. Breuer | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/7/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
ARTHUR S. BREUER | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Jan 10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Montgomery Md | | | |
| 24. FUNERAL DIRECTOR
Takara Funeral Home/Deaths Dept | | | | ADDRESS
354 CARROLL ST AN | | 25a. REC'D BY REGISTRAR
JAN 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

0133

10 JAN 1951

0133

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01337

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01333

| | | | | | | | | | | | |
|--|------------------------|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Ola Blanche Walsh | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 4 Year 1968 | | | 2b. HOUR 12:50 P | | | | | |
| 3. SEX
female | 4. RACE
cauc | 5. DATE OF BIRTH
April 2, 1902 | 6. AGE (In years) 65 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month 1 Day 4 Year 1968 | | | 2d. HOUR
12:55 P | | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Sil. Spring | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 13e. STREET AND NUMBER
10801 Georgia Avenue | | | | | | | | | | | |
| 14. FATHER'S NAME
Mandival | | | 15. MOTHER'S MAIDEN NAME
Mintie | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | | |
| 16a. SOCIAL SECURITY NO.
234-14-4577 | | | 17. INFORMANT
Thomas L. Walsh, 10801 Georgia Ave, S.S. Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
411.9
DUE TO, OR AS A CONSEQUENCE OF artery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Heart Disease
(b) Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED Jan. 4, 1967 | | | |
| EXAMINER'S NAME (Type) BELDEN R. REAP M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | Jan. 8, 1968 | | | | Cedar Hill Cemetery | | | |
| 23d. LOCATION (City or Town) (County) (State) | | | | 23e. REC'D BY REGISTRAR | | | | 23f. REGISTRAR'S SIGNATURE | | | |
| Suitland, Maryland | | | | Jan. 10 1968 | | | | Charles Judge | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01338 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last
OSCAR NMI Weigert | | | 2a. DATE OF DEATH
Month Day Year
JAN 7 68 | | | 2b. HOUR
6:45 AM |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
12 Aug. '86 | | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING
Cherry Chase | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CHEVY CHASE
NURSING AND CONV CENTER | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Economist | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
Mont | | 13c. CITY OR TOWN
Cherry Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
14-04 FORD ST. |
| 14. FATHER'S NAME
First Middle Last
Waldenburger - Weigert | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Emma - RAPPENHEIM | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
- | | 17. INFORMANT
Edith Card 1 | | Address
W-6-A-R | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u>
480X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>492X</u>
(b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>viral & bacterial infection</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>GEN. ARTERIOSCLEROSIS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>Jan</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>Jan</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Milton Gawler</u> MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1/7/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Milton Gawler | | | | | 22e. ADDRESS
1100 - 22, NW Wash DC 20037 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 23b. DATE
1/8/68 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREM. | | 23d. LOCATION (City or Town) (County) (State)
SUITLAND, MD. | | | |
| 24. FUNERAL DIRECTOR
SOS. GAWLER'S SONS, 5130 W. AVE., N.W.
WASH., D.C. | | | | | 25a. REC'D BY REGISTRAR
DATE JAN 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

01338

01338

OFFICE OF DESIGN

CONSTRUCTION OF THE NEW YORK STATE TOLL ROAD

JAN 10 1938

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01339

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01335

| | | | | | | | | |
|--|-------------------------|--|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or Print) NELLIE B. WELCH | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1 28 1968 | | | 2b. HOUR 9:30 M. | | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
12-29-93 | 6. AGE (In years last birthday)
74 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month 1 Day 28 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASH. SAN & HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
S.S. | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
714 SLIGO AVE. #302 | |
| 14. FATHER'S NAME
ANDREW | | | 15. MOTHER'S MAIDEN NAME
MARY | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | |
| 16b. SOCIAL SECURITY NO.
NONE | | | 17. INFORMANT
MRS. EVELYN TIBBS | | | ADDRESS
9234 ADELPHI RD ADELPHI, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS
W. W. Chambers Co. 8655 Ba Ave S.S. Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
Feb. 1 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Flint Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Dakota, Virginia | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co. | | | | ADDRESS
8655 Ba Ave S.S. Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

CHC10

WORLDWIDE TELEVISION

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WORLDWIDE TELEVISION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 397 Maryland Department of Health
2-5-68 as DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|---|------------------|--|---|---|----------------------------------|---|---|--|
| 1. DECEASED-NAME
(Type or Print) <i>Cara Lenora Wells</i> | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Jan 22 1968 | | | 2b. HOUR 4:00 PM | | |
| 3. SEX <i>F</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>Feb. 5 - 1920</i> | 6. AGE (In years last birthday) <i>47</i> YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN | 2c. DATE PRONOUNCED DEAD
Month <i>Jan</i> Day <i>22</i> Year <i>1968</i> | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Kansas</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Rockville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>883 Burdette Rd.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk-typist</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i> | | 13b. CITY OR TOWN <i>Rockville</i> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>803 Burdette Road</i> | | |
| 14. FATHER'S NAME First <i>Daniel Fling</i> Middle Last | | | 15. MOTHER'S MAIDEN NAME First <i>Brooks</i> Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>515-20-1908</i> | | 17. INFORMANT ADDRESS <i>Fred E. Wells - husband same item #10-11</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>PERMANENT Pulmonary congestion & Edema</i>
<i>854.0</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>overdose of Barbiturates</i>
<i>871.0</i>
DUE TO, OR AS A CONSEQUENCE OF (b)
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 hr.?</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Chronic endocarditis involving all heart valves</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
<i>3:00 P.M. Jan 22 19 68</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Took overdose of drugs</i> | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i> | | 21f. LOCATION Street or R.F.D. No. <i>803 Burdette Rd. Rockville Montg. Md.</i> | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>Jan 23, 1968</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | 7936 Old Georgetown Road Bethesda, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/27/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i> | | 19 ADDRESS <i>Rockville, Md.</i> | | 25a. REC'D BY REGISTRAR <i>Jan 25 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>William J. Jones</i> | | |

CERTIFICATE OF DEATH

01341

01337

| | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) JAMES | | | First LAYTON | | | Middle WEST | | | Last | | | 2a. DATE OF DEATH
January Month 11 Day 1968 | | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
September 10, 1903 | | | 6. AGE (In years last birthday)
64 | | | IF UNDER 1 YEAR
MONTHS 4 DAYS 1 | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Washington | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Garrett Park | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
10919 Clermont Ave. | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Credit Investigator | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington | | | | | | 13b. COUNTY D.C. | | | | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
3924 7th. St. N.E. | | |
| 14. FATHER'S NAME First ROBERT Middle LEE Last WEST | | | | | | 15. MOTHER'S MAIDEN NAME First ANNA Middle Last JOHNSON | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT
Address
Robert L. West - son - same item # 11 | | | | | | | | |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) CORONARY OCCLUSION</p> <p>4109 DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) CORONARY INSUFFICIENCY</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) ARTERIO SCLEROSIS</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4201</p> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| | | | | | | | | | | | | | | | 5 min. | | | | | |
| | | | | | | | | | | | | | | | 2 year. | | | | | |
| | | | | | | | | | | | | | | | 5 year | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | | | | | | | | | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | | | | | | | | | | |
| 21c. HDW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 11 , 19 68 , to 111 , 19 68 , that (I) (we) last saw the deceased alive on Dec 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Chas. V. Pate M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED 11/11/68 | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) CHAS. V. PATE M.D. | | | | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS 335 W ST N.E. WASH D.C. | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | | | | | 23b. DATE 1/13/68 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Darnestown | | | | | | | | |
| 23d. LOCATION (City or Town) (County) (State)
Darnestown, Montg. Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Address
Tyson Wheeler Funeral Home 1331 Rockville | | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DWAN 16 1968 | | | | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 01342 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01338 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) ELLENOR BARNES WHITNEY | | | | | | | | | | | | 2a. DATE OF DEATH
Month Jan Day 5 Year 1968 | | | | | | | | | | | | 2b. HOUR
8:00 P. | | | | | | | | | | | |
| 3. SEX
FEMALE | | | | 4. RACE
Caucasian | | | | 5. DATE OF BIRTH
Oct. 3, 1883 | | | | 6. AGE (In years last birthday)
84 YRS. | | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7501 Wyndale Road | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Montg. | | | | 13c. CITY OR TOWN
Chevy Chase | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
7501 Wyndale Road | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Joseph E. Barnes | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown - Fraser | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) ----- | | | | 16b. SOCIAL SECURITY NO.
577-01-5098B | | | | 17. INFORMANT
Address
Mrs. George Parton, Same as #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypochromic Anemia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 mo
5 years
14 mo | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4200
Carcinoma of Cervix
9 mo | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
--- | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1930 19 --- , to Jan 5 19 68 , that (I) (we) last saw the deceased alive on 12-22-1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
William T. Gill Jr MD | | | | 22c. DATE SIGNED
Jan 5-1968 | | | | 22d. PHYSICIAN'S NAME (Type)
WILLIAM T. GILL JR | | | | 22e. ADDRESS
1546-K Street N.W. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE
1/8/68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, | | | | ADDRESS
5130 Wisconsin Ave, NW | | | | 25a. REC'D BY REGISTRAR
DATE JAN 10 1968 | | | | 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

01343

CERTIFICATE OF DEATH

01339

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. LENGTH OF STAY IN 1b <u>4 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>14214 - Briarwood</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Walter E. Whitt</u> | | 4. DATE OF DEATH <u>Jan 14</u> 19 <u>68</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/13/85</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>68</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY EMPLOYEE -</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C. U.S.A.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C. U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Sidney Whitt</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Wade</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>579-26-9822</u> | |
| 17. INFORMANT <u>HOB.P. RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4339</u> IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>332X</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11</u> , 19 <u>68</u> , to <u>1-15</u> , 1968, that (I) (we) last saw the deceased alive on <u>1-14</u> , 1968, and that death occurred at <u>11:30</u> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>D. C. Bacy</u> | | 22b. DATE SIGNED <u>1-15-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>D. C. Bacy</u> | | 22d. ADDRESS <u>809 Veas Mill Rd Rockville</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>1-18-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Wheaton, Md.</u> |
| 24. FUNERAL DIRECTOR <u>James C. O'Sullivan - O'Sullivan Funeral Home - Wash. D.C.</u> | | 25a. REGD. BY REGISTRAR <u>JAN 22 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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STATE OF TEXAS

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Blank lined form area for text entry, containing faint horizontal lines and some illegible markings.

Vertical text on the right margin, likely a library or archival stamp, containing the words "LIBRARY" and "ARCHIVE".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01344 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01340 | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|---|--|--|--|--|--------------------------------|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
Luke Truman Wickey | | | | | | | | | | Month Day Year
Jan 27 1968 | | | | | | | | | | 7:45 A.M. | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Cauc. | | | 5. DATE OF BIRTH
5-28-93 | | | 6. AGE (In years last birthday)
74 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Pa. | | | 7b. CITIZEN OF WHAT COUNTRY?
Amer. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WSH | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | | 13b. COUNTY
— | | | 13c. CITY OR TOWN
Wash, D.C. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
7708 12th Street, N.W. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
William O. Wickey | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Jennie — Hartman | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
578-03-3583 | | | 17. INFORMANT
WSH | | | Address
7600 Carroll Ave | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>401x PNEUMONIA</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE AND ARTERIOSCLEROTIC</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>VASCULAR DISEASE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 WEEKS</u>
<u>13 YEARS</u> | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>593x</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT, 1954</u> , to <u>JAN 27 1968</u> , that (I) (we) last saw the deceased alive on <u>JAN 26 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert L. Krichmar MD</u> | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>JAN 27 1968</u> | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT L. KRICHMAR MD | | | 22e. ADDRESS
7733 MASHA BLVD N.W.
WASHINGTON DC 20012 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
1/29/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEM. | | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON, D.C. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
JOS. GAWLER'S SONS | | | ADDRESS
5130 WIS. AVE, NW
WASHINGTON, D.C. | | | 25a. REC'D BY REGISTRAR
DATE JAN 31 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01341

| | | | | | | | | | | | |
|---|---------|--|--|--|------|---|------|---|-----------------------------------|--|-----------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Estelle Elizabeth Williams | | | | | | Month 1 Day 5 Year 1968 | | | 8:30 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Female | white | 4/3/81 | 86 YRS | MONTHS | DAYS | HOURS | MIN. | Month 1 Day 5 Year 1968 | | | 9:20 P.M. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Brookeville | | | Rt. 1, Box 45 | | | housewife | | | none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | | Brookeville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Carmel Cemetery Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| William P. Stevens | | | Alice Price | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | unknown | | | Montgomery Gen. Hospital | | | Olney, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4301 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | ASSISTANT MEDICAL EXAMINER | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | M.D. | | | DEPUTY MEDICAL EXAMINER | | | JAN. 6, 1968 | | |
| Beldon R. Reap, M.D. | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | Jan. 9, 1968 | | Cokesbury Memorial | | Abingdon | | Harford | | Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Howard K. McComas & Son, Abingdon, Md. 21009 | | | | | | | | DATE JAN 10 1968 | | Charles Judge | |

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RECEIVED
JAN 10 1968
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

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FOR STATE

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JAN 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR P. | |
| Varina | | | Davis | | Winn | Jan. 1, 1968 | | 8:30 M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | Caucasian | | June 13, 1881 | | 86 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Virginia | | U.S.A. | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spr. | | | | 726 N. Belgrade Street | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| John | | | William | Holloway | Elizabeth Susan | Raines | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| None | | | None | | Vernon C. Winn | | | | 4109 Jessenden Street, N. W. Washington, D. C. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u>
2509 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes Mellitus</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7-8 yrs
?
5-10 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
260x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1947, to Jan. 1, 1968, that (I) (we) lost saw the deceased alive on Jan. 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William D. And | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1 Jan 68 |
| 22d. PHYSICIAN'S NAME (Type)
William D. And | | | | | 22e. ADDRESS
9006 Colesville, Rd., Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Burial | | Jan. 4, 1968 | | Mt. Olivet Cemetery | | Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR
JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|---|---|---|--|----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 01343 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Frank | | | E. Withers | | | 1 Month 5 Day 68 Year | | 2:30 P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | | White | | 28, 1883 | | 87 84 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Virginia | | U.S.A. | | | | Montgomery Co. Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | | | Potomac Valley Nursing Home | | | Sawmill Operator | | Lumber | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Rockville | | YES | | 15900 Frederick Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| George Withers | | | Frances Dameron | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 229-16-4075 | | William B. Withers-son- 304 Luckett St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) DRUNK PNEUMONIA | | | | | | | | 1 DAY | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) SENILITY | | | | | | | | 4 years | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 491X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | | | Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 1967, to JAN 5, 1967, that (I) (we) last saw the deceased alive on JANUARY 4, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| William Frank, M.D. | | | | | | | | | JAN 5, 1967 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| WILLIAM FRANK, M.D. | | | | | 1125 ROCKVILLE PIKE ROCKVILLE, MD. | | | | | |
| 23a. BURIAL, CREMATION, ETC. (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1/7/68 | | Totuskey Cemetery | | Haynsville, Virginia | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Tyson Wheeler Funeral Home | | | | | 1331 Rock Pike | | DATE JAN 12 1968 | | Charles Judge | |
| | | | | | Rockville, Maryland | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01344

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Minerup Elizabeth Wolfrey</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>Jan 28 68</i> | | | 2b. HOUR
<i>6 A M</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>1-2-95</i> | | 6. AGE (In years last birthday)
<i>73</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Va</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Amer.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Washington San + Hosp</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Burtonsville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>2918 Spencerville Rd</i> | | 14. FATHER'S NAME First Middle Last
<i>Straghter Wolfrey</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Elizabeth Minnick</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>1560</i> | | 17. INFORMANT
<i>Mr. Willie J. Wolfrey</i> | | 2018 Address
<i>Spencerville Rd. Burtonville, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>UREMIA, acute due to</i>
<i>1560</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1551</i>
(b) <i>progressive renal failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>post surgical metastasis of gall bladder</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dilated liver associated with extrahepatic obstructive jaundice</i> | | | | | | | |
| 19a. DATE OF OPERATION
<i>1-28-68</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Cholecystectomy</i> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 18</i> , 19 <i>68</i> , to <i>Jan 28</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1-27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. <i>(Pronounced dead by house Dr)</i> | | | | | | | |
| 22b. SIGNATURE
<i>John R. Spencer, MD</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>1-28-68</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>John R. Spencer, MD</i> | | | | 22e. ADDRESS
<i>BURTONSVILLE, MD.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>Jan. 31, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Union Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Burtonville Mont., Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Warner C. Humphrey, Inc.</i> | | ADDRESS
<i>8434 Georgia Avenue Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>FEB 1 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|--|--|
| 01340 | | 01345 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>
c. LENGTH OF STAY IN lb <u>2mo. 5days</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u>
b. COUNTY <u>Washington, D.C.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u> | | d. STREET ADDRESS <u>610 Farragut St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Walter Nathaniel Woodruff</u>
First Middle Last | | 4. DATE OF DEATH <u>January 20 1968</u>
Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/3/1888</u>
Month Day Year |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Wyatt Woodruff</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Aurelia</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>4339</u> | |
| 17. INFORMANT <u>Robert T. Dill</u> | | Address <u>1-20-68</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>33</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>46 days</u>
<u>indefinite</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Rheumatoid + Degenerative arthritis ; (2) Diabetes Mellitus - adult type</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>67</u> , to <u>1-20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> , 19 <u>68</u> , and that death occurred at <u>7:45</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert T. Dill</u> (M.D.) | | 22b. DATE SIGNED <u>1-20-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>1/24/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u> | 23d. LOCATION (City or Town) (County) (State) <u>Belton Co. Va</u> |
| 24. FUNERAL DIRECTOR <u>John T. Fluor</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>3015 12 St. N.E.</u> | | DATE <u>JAN 26 1968</u> | |

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DEPT OF DEAF

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John T. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 01350 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 01346 | | | | | | | | | | | |
| George | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last George Arthur Worth | | | | | | | | | | | | 2a. DATE OF DEATH Month Day Year January 26 1968 | | | | | | | | | | | | 2b. HOUR 8 ⁰⁰ A.M. | | | | | | | | | | | |
| 3. SEX Male | | | | 4. RACE white | | | | 5. DATE OF BIRTH 10-10-15 | | | | 6. AGE (In years lost birthday) 52 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) New York | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Takoma Park | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Customer Liaison | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Montgomery | | | | 13c. CITY OR TOWN Silver Spring | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER Apt. 921 8811 Colesville Road. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Arthur Worth | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Edna Foote | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO. Mary-1000 | | | | 17. INFORMANT Hosp. records | | | | Address | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarct
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS
YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1966, to 1/26/68, that (I) (we) lost saw the deceased alive on 1/26/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Albert H. Grollman | | | | DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/26/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | ALBERT H. GROLLMAN, MD | | | | 22e. ADDRESS 1106 SPRING ST. SILVER SPRING MD | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL-CREMAATION, REMOVAL (Specify) | | | | 23b. DATE Jan. 29-1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum | | | | 23d. LOCATION (City or Town) (County) (State) Silver Spring Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Arthur Wallers | | | | ADDRESS 334-Camel St | | | | 25a. REC'D BY REGISTRAR JAN 30 1968 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | |

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Rhonda | | | | | WRIGHT | JAN 12 1968 | | | 3:16 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Female | | White | | 1/12/68 | | YRS. | | 8 16 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | | | Holy Cross | | | none | | | none |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Jakoma Park | | | 8704 Barron Street | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Joseph C. Wright | | | | | | Evelyn Marshall | | | XXXXXXXXXXXX |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| no | | | none | | | Father | | | 8704 BARRON ST. Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
777X
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
776X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12, 1968, to Jan 12, 1968, that (I) (we) lost saw the deceased alive on Jan 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
H. H. Diamond M.D. | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
1-13-68 |
| 22d. PHYSICIAN'S NAME (Type)
H. H. DIAMOND | | | | | 22e. ADDRESS
911-SILVER SPRING AVE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | Jan 15, 1968 | | Elk Creek Cemetery | | Elk Creek | | Virginia | |
| 24. FUNERAL DIRECTOR
C. Glen Carter 8434
Warner E. Pumphrey, Inc. Silver Spring, Md | | | | | ADDRESS
Ga. Avenue | | 25a. REC'D BY REGISTRAR
DATE JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

File Copy

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

2001. 21. 10.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|--|----------|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| James | | | Arnold | Wyatt | January 19, 1968 | | | 8:20 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | White | | March 24, 1911 | | 36 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Virginia | | American | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Takoma Park | | | Washington Sanitarium & Hospital | | | Car Salesman | | Automobiles | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery Silver Spring | | | | 910 Noughoe Drive | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | |
| William | | | Wyatt | | | Minnie Verona Hicks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| no | | | 578-14-7450 | | Mrs. Kathleen Wyatt Hospital Records | | 910 Noughoe Drive Langley Park, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u>
<u>571.8</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Unknown</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>5810</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>68</u> , to <u>1/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold B. Tidler M.D.</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>1/20/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Harold B. Tidler</u> | | | | | | 22e. ADDRESS
<u>8402 Genton Street, Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>Burial</u> | | <u>Jan 22, 1968</u> | | <u>Cedar Hill Cemetery</u> | | <u>Suitland, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JAN 23 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01332

01332

1

0215-01-17

JAN 8 1968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

01353

01349

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|---|----------------------|---|---|---|
| 1. DECEASED NAME
(Type or Print) First Middle Last
Ralph B. Wyman | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 1 Day 8 Year 1968 | | 2b. HOUR 5:30 P.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH January 26, 1885 | 6. AGE (In years last birthday) 82 yrs | 7c. DATE PRONOUNCED DEAD 1-8-68 Year 1968 Day 8 Hour 5:30 P.M. |
| 7a. BIRTHPLACE (State or foreign country) Maine | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH Montgomery | | 10. CITY OR TOWN OF DEATH Silver Spring | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 125 Eastmoor Drive | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telegraph | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Silver Spr. |
| 14. FATHER'S NAME First Middle Last
Charles Wyman | | 15. MOTHER'S MAIDEN NAME First Middle Last
Alice Belgrade | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 006-03-3635 | | 17. INFORMANT Carmelite Randall |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) due to suffocation, apparently self-inflicted.
DUE TO, OR AS A CONSEQUENCE OF (c) self-inflicted. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
979x | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 5:00 P.M. 1-8-68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Deceased wrapped in plastic bag about face. |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory/office building, etc.) Home | | 21f. LOCATION (Street or R.F.D. No. City or Town County State) 125 Eastmoor Dr. Silver Spring Montg. Md. |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Belden R. Reap | | 22b. DATE SIGNED JAN. 9, 1968 | | |
| EXAMINER'S NAME (Type) Belden Reap M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery |
| 24. FUNERAL DIRECTOR Clark E. Wisor | | 25a. REC'D BY REGISTRAR DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

2310.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
|---|-----------|--|--|---|---|---|--|---|-----------------------------------|--|--|
| First | Middle | Last | | Month | Day | Year | | | | | |
| ANNA | CATHERINE | YOUNG | | JANUARY | 19 | 1968 | 10 15 A.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| Female | | White | | 8-28-96 | | 71 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| New York | | U.S.A. | | | | Montgomery | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | | Washington San. & Hospital | | | Housewife | | | AT HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | | Takoma Park | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8302 Flower Avenue | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Matthew | | | Mareka | | | Catherine | | | Valaitis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 220-54-0394 | | | Records Wash. San. & Hosp. | | | Takoma Park | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE CORONARY INSUFFICIENCY & ARTERIOSCLEROSIS | | | | | | | | | | 3/4 HR. | |
| 1541 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) INT ESTINAL OBSTRUCTION | | | | | | | | | | 1 WEEK | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) CARCINOMA OF RECTUM | | | | | | | | | | 1 YR | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 154X SEE b. & c. ABOVE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 1-14-68 | | INTestinal Obstruction | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-12-68 to 1-19, 1968, that (I) (we) saw the deceased alive on 1-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Dwight R. Smith M.D. | | 1-19-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| DWIGHT R. SMITH | | 800 PERSHING DRIVE SILVER SPRING, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Jan 23, 1968 | | St. Johns Cemetery | | Middle Village, New York | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Arthur Waters | | 254 Carroll St. N.E. 20012 | | Charles Judge | | | | | | | |
| | | DATE | | JAN 22 1968 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01355 CERTIFICATE OF DEATH 01351 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Charles T. Young | | | | | | Month Day Year
Jan 15 1968 | | | 5:50 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| male | | white | | 5-29-1891 | | 76 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Washington, D.C. | | | U.S.A. | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | | 6202 Wedgewood Road | | | Retired | | Laundry | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Montgomery | | Bethesda | | | | 6202 Wedgewood Road |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Unknown | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 579-01-6325 | | Clara W. Young - See Item 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia Bronchiale</u>
471 X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>480 X</u>
(b) <u>Flu</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Vascular Thrombosis</u> 4 1/2 years | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Weeks
3 Weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> , to <u>Jan 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>P.P. Andrews M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>1-15-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u> | | | | | | 22e. ADDRESS <u>WASHINGTON DC 20016</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-18-1968 | | Columbia Gardens Cemetery | | Arlington, Va. | | | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wash. Bldg. Ave. NW</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 22 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01356 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01352 | | | | | | | | | | | |
|---|--|--------|--|--|--|--------|--|--|--|--|---------------------------------|--|-----------------|--|------------------|--------|--|----------|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2c. DATE OF DEATH | | | 2b. HOUR | | | | | | |
| MORRIS | | | | | | | | ZIPKEN | | Month 1 - Day 8 - Year 68 | | | 7 1/2 A. M. | | | | | | |
| 3. SEX | | M | | 4. RACE | | W | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| | | | | | | | | 11-15-1898 | | | 69 YRS. | | MONTHS | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? | | USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| | | | | | | | | | | MONTGOMERY Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| CHEVY CHASE | | | | BETHESDA SILVER SPRING N.S.C. HOME | | | | | | | | Newsdealer | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| MD | | | | MONTGOMERY | | | | SILVER SPRING | | | | 2250 WASHINGTON AVE | | | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | |
| David | | | | Zipken | | | | | | Edith | | | | Krahl | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | | | Address | |
| | | | | CH-16-2821-A | | | | Mrs. Ada Zipken (wife) | | | | | | | | | | as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) SEPTICEMIA | | | | | | | | | | | | | | 3 days | | | | | |
| 342x DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | 4 months | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 350x | | | | | | | | | | | | | | 10 years | | | | | |
| (b) Multiple decubitus ulcers | | | | | | | | | | | | | | | | | | | |
| (c) Advanced Parkinsonism | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| Arteriosclerotic heart disease | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-6-68, to 1-8-68, that (I) (we) last saw the deceased alive on 1-6-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | |
| Jason GERGER, M.D. | | | | 1-8-68 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| Jason GERGER, M.D. | | | | 500 PERSHING DRIVE SILVER SPRING, MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | 1-10-68 | | | | Wash. Hebrew Cong. Cem. | | | | Washington, D.C. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | | | | | |
| Gernard Lanzansky and Sons 3521-14th St. N.W. Washington, D.C. 20010 | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| DATE JAN 12 1968 | | | | | | | | | | | | | | Richard Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

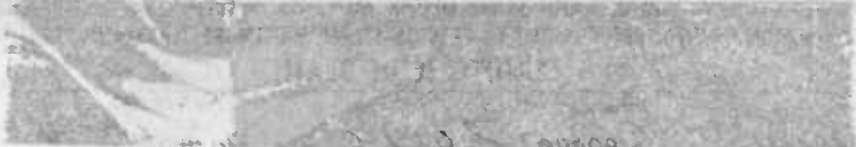
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Med examiner - Dr. [Signature] Notified & Approved

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|
| 01357 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01353 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
ANTHONY George ZOLLO | | | | | | | | | | 2a. DATE OF DEATH Month 6 Day 68 Year
JANUARY 6 68 | | | | | | | | | | 2b. HOUR
1:10 P M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
M | | | | | | | | | | 4. RACE
WHITE | | | | | | | | | | 5. DATE OF BIRTH
3/22/17 | | | | | | | | | | 6. AGE (In years last birthday)
59 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
CONN. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
MONTGOMERY COUNTY Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Accountant | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Nat'l Red Cross | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | | | | | | | 13b. COUNTY
MONTGOMERY | | | | | | | | | | 13c. CITY OR TOWN
SILVER SPRING | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER
806 STERLING RD. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Jerry Zollo | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
511-01-7834 | | | | | | | | | | 17. INFORMANT
Mrs. Edith F. Zollo | | | | | | | | | | 806 Sterling Road Silver Spring, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 174X
Carcinoma of Breast
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January, 1967, to January 6, 1968, that (I) (we) last saw the deceased alive on January 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
BLAINE H. EIG | | | | | | | | | | 22c. DATE SIGNED
Jan 6, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
BLAINE H. EIG | | | | | | | | | | 22e. ADDRESS
9801 Georgia Avenue, Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
Jan. 9, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. FUNERAL DIRECTOR
C. Glen Carter | | | | | | | | | | 24b. ADDRESS
8434 Georgia Avenue | | | | | | | | | | 25a. REC'D BY REGISTRAR
JAN 10 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Warner E. Pumphrey, Inc. | | | | | | | | | | Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "received" and "date" are faintly visible.

Handwritten text, possibly a signature or name, appearing as "C. J. ...".

Handwritten text at the bottom of the page, including "BLANK H-1" and "Q. 12".

Handwritten text at the very bottom, including "1981" and "1982", likely indicating dates.